Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:45 p **Barbara Molock** Apr 18, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Future Care-Irvington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Aspette Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 ☑ F Yrs Director Dec 21, 1940 Maryland 217-38-4382 68 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1224 South Carey Street 21230 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify. Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City School Para Professional 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Johnson Ernest Johnson P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1224 South Carey Street Baltimore, Maryland 21230 Trevia Boozer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04/22/09 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each life.

Immediate Cause (Final disease or condition resulting in death)

a. The to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-trar and Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for Day Vear in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. the □Yes 2 PNo 9 Unknown 9 ☐ Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by been signe should be o on 1 ☐ Yes 2 No 3 Probably 4 Wnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 DOA 1 ☐ Inpatient this (ဥ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number 39127 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) DR A.Ame ST. Butimore 21201 21 Al- Endlaw

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Lee Maczka April 1 25,20°9 11:15am /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Nursing Center Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Year Months Days Hours Min 220-22-3521 1 M 25 MF 87 Director Nov. 29, 1921 MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Modical Exagination in the modified 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 406 Riverside Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ≥ 1 ☐ Yes 2X No Specify. White Specify 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 6th Grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an Drive Nanticoke MD 21840 2265 Water View William Geary / nephew other permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State St. Stanislaus 4/30/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Licensee al Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that cause at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ing. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Simers be menta disease or condition resulting in death) 100 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 Tyes 2 No. 9 Unknown ۾ cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation hours after death. 1 ☐ Yes 2 No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

the Hospital within 24 hours a

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Maurice Downing Meyers 01:30рм 09 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 416 Holly Farms Road Severna Park Anne Arundel Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Director 220-03-6347 100 Sept 30,1908 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes XX No Director Maryland Anne Arundel Co. Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Holly Farms Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. TXYes 2□No WWII & IfYes, Give Year or Dates:Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) yrs. Lt. Colonel U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank C. Meyers Sarah E. Sturges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph V. Prado/ Son-in-Law 507 Washington St. Cumberland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baldwin Mem. UMC Cem. May 1, 2009 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Fune M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KIDNEY DISFASE CHRUNIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ADRENAL INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☑ No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 ✓ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Shandn 27.09 MID 055113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHENTON 1132 ANNAPOLIS 21113 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 28 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22, 1:30 p M April 2009 William D. MacAleese 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carrol1 Finksburg 122 Lassiter Circle 8. Date of Birth (Month, Day, Ye Oct. 15, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1933 Massachusetts 216-28-9138 75 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Maryland | Carroll Finksburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 United States 122 Lassiter Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates Korean War 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Racing Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Harvie William C. MacAleese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy MacAleese Wife 122 Lassiter Circle; Finksburg, MD 21048 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 4/27/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. Mortician Lic 21. Signature of Funeral Service Lice M01537 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UPUI Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Ur denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2010 1 ☐ Yes 2 X No 1 ☐ Yes 26. Place of Death (Check only o Hospital: Other: 4 \sum Nursing Home 5 Residence 6 □ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined

Physician /Medical Examiner requires that the death certificate be executed Box 68760 P.O. of Vital Records, Hospital or Attending Physician: Division To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Ai completely filled in by the fu

Physician

Examiner

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

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Director

Funeral

Completed by

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Physician/Medical

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Completed

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Certification: To

Medical

physician and s the burial-trans

attending p for use as t

cate has been signed by the page 2 should be detached

After this certificate has

funeral director,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Dr ath 1 Natural 2 Ascident 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

205 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 7:45P 2009 Sr. M. Angeline McGrath, R.S.M. April 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Villa Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 K Yrs. 2-8-1914 95 MD Director 215-56-5414 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is 15 to refifted at once. 1 ☐ Yes 2X No Director Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA 6806 Bellona Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14, Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐KNo Specify Yes. Give <u>6</u> Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Religious Sister</u> Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Daniel J. McGrath <u>Agnes M. Shetla</u> 19a. Informant's Name/Relationship (Type. Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sisters of Mercy-Mercy Drive, Belmont, NC 28012 Order 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4-27-09 Woodlawn, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road PA, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ather sclent c Cardio vasulon disease **Physician** 10 YV8 resulting in death) /Medical Due to (or as a consequence of) Examiner dement 107vst Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 1 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Ye ar Month 12:19PM **Physician** Timothy N. Morgan April 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8035 Wood Avenue Edgemere Baltimore Co. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 218-58-7348 57 22,1951 West Virginia Usual Residence of Decedent 10d. inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylax Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Event is at must be multified at once. 1 ☐ Yes 2 XNo Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8035 Wood Avenue 21219 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Railroad Brakeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glendora F. Dean Jeremiah M. Morgan ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1532 Robinson Mill Road Street, Maryland 21154 Winona Hancock (Sister) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2009 Oak Zawn Cemetery 5 ☐ Other (Specify) Baltimore, Maryland 4 ☐ Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Marvland 21222 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like Immediate Cause (Final disease or condition resulting in death) Sho pa <u>a.Se</u> **Physician** a /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 2 XNo 1 ☐ Yes ours after death.

eral Director: After this certificatilled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Self in flicted 1 | Natural 5 Pending investigation gun shot toabdomen April 22,2009 1219 P 1 ☐ Yes 2 X No 2 Accident 6 ☐ Could not be lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 8035 WOOD AVENUE Edgemere Maryland ZIZIG 3 Suicide 28e. determined 4 ☐ Homicide 24 hours a 29a, Certifier To the Hospi within 24 hou To the Funel completely fil Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 20

31. Date filed (Month, Day,

32. Begistrar's Signature

Deven D. Sauls

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MD

Sle Hill CT. Luther

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland		artment of H		ental Hygie	ene g. No2 0 0 9	13507
	Physicia	an	1. Decedent's Name (First, Middle, Last) Nicholas	н.	Montar	ari Ir	2. Date of Death April 2.	3, Day 2009 Year	3. Time of Death 12:32P M
,	/Medic Examin		4a. Facility Name (If not institution, give street and number) 245 Patapsco Avenue		4b. City, Town, or Dunda		4c. County of Dea		
	Funeral Director		5. Social Security Number 218−32−9858	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, Feb. 13,	9. Bii 1938 Ma	rthplace (State or Foreign ountry) ryland
	show	J.	- 1	Town or Lo	cation	Dunda	1k		10d. Inside City Limits 1 ☐ Yes 2 ♣ No
	th the Ma or 28a-f	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	
	death w	Funeral Director	245 Patapsco Avenue 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13.		21222 spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No-	United S	erican Indian,
900	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Madical Even in a routh or notified at		1 ☐ Never Married 2 ☐ Married IX☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2 X 3XNo	Specify:		Specify:	White
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Maryland 21215-0036	d 2 should be filed th and Mental Hyg 7 is marked othe traumatic event,	2	Nicholas H. Montanari, Sr. 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a	and Number or Rura	I Route Number,	City or Town, State,	Zip Code) 21 08 7
re, M	1 and Heal Heal Sem 2		27	ace of Dispo	osition (Name of	e) D	ate 2	Oc. Location - City o	
Baltimore,	permit. Pages Department of Important: If II any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation—5 ☐ Other (Specify) 21. Sign of e of From Service Seese	lltop	Service C	orp. 4/27 Sept Facility Funeral H		Towson, N	
Ba	Dep any onco	1 6	23a. Part 1. Enter the disease, or complications that caused the death		7922 Wise	Ave. Du	ndalk, N	Maryland	Inc. 21222 Approximate
	Physician		snock, or neart failure. List only one cause on each line. Immediate Cause (Final disease or condition	2 .	1 Infa	rction	7		Interval Between Onset and Death
	/Medical Examiner	L	resulting in death) Due to (or is a consequence of the control of	rate 4	Lypon	rction tensio	4		20 years
36	scuted ind transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
3760,	ate be executed hysician and the burial-transit	<u>ica</u>	resulting in death) Last Due to (or as a consequence of the consequen	ience ot):					
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
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	ine ine	tion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	28b. Time e Injury	of 28c. Injur Worl			w injury occurred	
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0	To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knot one) Medical Examiner: On the basis of examina and manner stated.	wledge, dea	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, de	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens	se number	2:	9d. Date signed (Mo 4 · 24 · 0 9	onth, Day, Year)
	5+1		30. Name and address of person who completed cause of death (Iter	n 23a) (Type	Alam R1	Corke	ysulle	9d. Date signed (Mo 4 · 24 · 0 9 . M. D. 2	1030
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 28 2009	iture	allah .				

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			1 - State of Ma Registrar	ryland / Dep. <i>Ce</i>	ertificate of			ene g. No. 2 A A C	13508			
	Physici	an	1. Decedent's Name (First, Middle, Last) ROBERT LOUIS MER	GEHENN			2. Date of Death	6, Day 2009 Year	3. Time of Death 7:30 P M			
- Second	/Medic Examin		4a. Facility Name (If not institution, give street and number)		nprii 2	4c. County of Deat						
Υ΄	Funeral			(In yrs. last birthday	Balt: // If Under 1 Year Months Days	8. Date of Birth (Month, Day,	N/A 9. Birt	hplace (State or Foreign untry)				
	Director		Usual Residence of Decedent	1 № 2 F 61 Yrs. Months Days Hours Min. (Month, Day, Year) Apr 10, 1948								
	Aarylan f show	ō	Maryland N/A	10c. City, Town or L	ltimore C	itv			10d. Inside City Limits 1 XYes 2 □ No			
	or 28a-	Funeral Director	10e. Street and Number		, 10f. Zip Code		10	g. Citizen of What Co	untry?			
	s 23a	eral	2428 Kentucky Avenue 11 Marital Status 12. Was Decedent E	vor in IIS 12	Was Dosedent of h	21213	acify Yas or No-	USA 14. Race - Ame	rican Indian			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Event are must be positived an once.	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent 12. Horned Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	0	S. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 汉No	Specify:	Rican, etc.)	Black, White				
215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupie kind of work done DO NOT use retire	oation during most of work	ing	6b. Kind of Business/ Baltimor	-			
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pu	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last)	_		18. Mother's Name						
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	and 2 sealth ar		J.Alan Spoler (Pers. Rep.)					Maryland				
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Baltimore,	nit. Pa partmer cortant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Femeral Service Deprese		Park Cemet			Baltimore,				
Ä	permi Depar Impor any ir		Martin D. Lawson		JOO TOLK	road, bal	rimore,	HOME, INC. Maryland 2	1212			
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,092	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last Due to (or as a	consequence of):								
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O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 🗌 Fetal death 3	B	су		23d. Date of del Month	livery Day Year			
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of Vital Records,	sician; The law re certificate has be irector, page 2 sho	Completed				<u></u>	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of			
Vita	sician; certific rector,	Be	25. Was case referred to medical examiner?		ient all poe Oth	or:	h (Check only one					
on of	nding Physician: The Ith. th. : After this certificate has funeral director, page	Certification: To	1 Yes 2 No	nt 2 ER/Outpati ry 28b. Time (Yea <i>r</i>) Injury	of 28c. Inju	4 LI Nursing Ho	28d. Describe ho	nce 6 ☐ Other (Spe w injury occurred	cify)			
Division	after death Director:	ertifica	a Double 6 D Could not be	ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (Str City or Town,	reet and Number or Ri , State)	ural Route Number,			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) A Certifying Physician: To the best of Medical Examiner: On the basis of and manner states.	examination and/or								
	To the To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number	29	Od. Date signed (Mont	h, Day, Year)			
			30. Name and address of person who completed cause of de	ath (Item 23a) (Tyro	D5	1715		4/4/2	04			
			Pamela Lin, M.D., 7801 Yor	k Road, S	uite 102,	Towson,	Maryland	21286				
	Sta Registr		APR 2 8 2009 Server	r's Bignature								

09-03195 Beatrice Mayo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ *edical Examiner 1240 hrs April 21, 2009 BEATRICE E. MAYO 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5002 Goodnow Road Apt. D Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Funeral oreign Hours Director 1-26-1925 219-18-5358 2 X F 84 Country) MARYLAND Yrs Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE filed within 72 hours after death with the Maryland irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 靣 5002 GOODNOW RD D 21206 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: Divorced Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CASHIER GROCERY STORE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages I and 2 should be fing artment of Health and Mental I portant: If item 27 is marked 8 CHARLES BAKER LAURA LeCOMTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Σ CHERYL BACLEY (GREAT-NIECE) 41st ST. BALTIMORE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Baltimore, crematory or other place) 1 X Burial Cremation 3 Removal from State -30-200**9** GARRISON FOREST VETERANS OWINGS MILLS, MD. Other Specify see JONATHAN HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician ailure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease mmediate Cause (Final disease ∕Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ σ. 1 Yes 2 No 3 Probably 4 V Unknown pleted 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Com performed' death? certificate Yes 2 ✔ No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA Inpatient After this 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Pending 1 Yes 2 No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be determined the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2009 **OCME** 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Virgil 12:00 P M 24, Dee Mills 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford 2304 Titan Terrace Havre de Grace If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 2/15/1924 1**∑**M 2□F 85 454-20-9693 Oklahoma Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21078 2304 Titan Terrace U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 D Yes 2 □ No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Govt. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Greenleaf Mills Ida Elizabeth Clemmons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Titan Terrace, Havre de Grace, MD Yvonne Mills (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 5/1/09 Harford Mem. Gdns. Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. of Puneral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acciden **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-trar Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Linknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ZNo 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Ite Martello MD 31. Date filed (Month, Day, Year) State APR 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** 3:27 A. April Ethel Ruth Novotny /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Rel Air 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1925 Maryland 1 □ M 2/20x 83 Director 219-18-6466 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the the control examiner must be retitled at 1 ☐ Yes 🏋 No Directo Maryland Harford Edgewood death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 United States 220 David Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2∏xNo Specify: Specify: White 2 3 □Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Brown Robert B. Stecker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1910 Phillips Mill Rd. Forest Hill, MD 21050 Arthur Novotny, Jr. / Son 20c. Location - City or Town, State Date 20a. Method of Disposition Evans Funeral the Chapel 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 28, permit. Pages
Department of
Important: If it
any injury or c 5 ☐ Other (Specify) Forest Hill, Maryland 4 □ Donation Bel Air 2009 22. Name and Address of Facility
Evans Funeral CHapel & Cremation Services—BelAir
3 Newport Drive Forest Hill, Maryland 21050 o Funeral Septice Licensee 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only be caused in each line. Immediate Cause (Final **Physician** pra disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami Cal attending physician and for use as the burial-trar as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) s been signed by the should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy performe 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending 1 □Yes 2 □ No investigation hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registra

30. Name and address of person who complete prause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Maryland / Department of Health and Mental Hygiene 09-03200 Jerome E. Nock 2009 13512 Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 21, 2009 1155 hrs Medical Examiner Nock, Jerome Ε. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death VA Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Days Months Hours Min Director Country) 214-38-6670 1X M 2 F 68 Yrs 2 /21/1940 Md. Usual Residence of Decedent 10d. Inside City Limits Ę, 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. Baltimore N/Ates 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Md. Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Rock Glen Rockland Road 210 South 21229 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 X Married 1 X Yes If item 27 is marked other than "natural", or f Yes, Give Year Yes 2 X No specify: Specify: Black Widowed Δ Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 US Post Office 12 Postal Employee 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Burrel1 Louise Nock William et and Number or Rural Route Number, City or Town, State, Zip Code)
Rock Glen
Rockland Rd., Baltimore. Md ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Juanita Nock 210 South Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) or other 1 XBurial 2 Cremation 3 Removal from State mportant: Department 4/30/2009 Owings Mills, Md. Garrison Forest Donation_5 Other Specify 21. Signature of Funeral Service ²² Hame and Address of Facility
Estep Brothers Funeral Service, PA
1300 Eutaw Place, Baltimore, Md.2 Md.21217 23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician veen Onset and /Medical Death a Hemopericardium Immediate Cause (Final disease or condition resulting in death) kaminer Due to (or as a consequence of) b ruptured dissecting aortic ancurysm-Ruptured aortic dissection Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical 892 6/12/09 TT F PII, per ME 8893 7/21/09 TT per ME e attending physician for use as the burial -UNPENDED X AMENDED Division of Vital Records, P.O. Box 68760, To the Tospital or Attending Physician: The law requires that the death certificate be within 24 hours after death IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed ficate has been s. page 2 should b 24b. Were autopsy findings available 24a Was an Diabetes mellitus prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 Nο 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, æ Hospital: 1 Inpatient 2 Other2 DOA Nursing Home 5 Residence 6 ER/Outpatient 1 Yes 28a. Date of Injury (Month, Day, Year) After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 🗸 Natural Pending Yes 2 To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) OCME O.C.M.E April 22, 2009

State Registrar

ADD 9 8 2009

30. Name and address of person who completed cause of death (Item 23a)

eador

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

32. Degistrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Verla Marguerite Niespodziewanski 9:53 PM April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 519 N. Paradise Road Harford 9. Birthplace (State or Foreign Aberdeen If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Min. 1 □ M 2 💢 F Hours 11¹/¹/²/4/¹/¹/²/4/¹/¹/¹/ 221-01-7767 91 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director Harford MD Aberdeen 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 N. Paradise Rod 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married No No 1 ☐ Yes 2 🗷 No Specify: White ģ Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin McLaughlin Verla Snyder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Hardy (Daughter) 519 N. Paradise Rd. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cathedral Cemetery 4/27/09 4 ☐ Donation Other (Specify) Wilmington, DE meral Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part1. Enter the discussed. If complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avonin disease or condition resulting in death) Due to (or as a consequence of) purminor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending Injury 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed o. ٦. or Vital Records,

Physician

Examiner

Funeral

Director

?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Be

filed within Hygiene.

and Mental Hygie Is marked other

f of Health

Department of Important: If It any injury or conce.

Physician

/Medical

Examiner

attending physician and for use as the burial-trar

certificate

after death.

Director: /

within 24 hours To the Funeral

the

filled in by

Examiner

Physician/Medical

9

Completed

Be

Certification: To

Medical

Maryland 21215-0036

Baltimore,

Division or Attending

State Registrar

31. Date filed (Month, Day,

5wp

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only

> ewil 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MB

29d. Date signed (Month, Day, Year)

09

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print MAMMOUD

29c. License number

ye Road Wastminister

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland		artment of I		ınd Mer		ene g. No.20	09	13515
	Physici	20	1. Decedent's Name (First, Middle,	Last)						Date of Death Month	Day	Year	3. Time of Death
	/Medic		BERTHA			PE	RREAU			PRIL	27	2009	2:25 AM
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Ŋ,	Funeral Director		218-34-2534	1 □ M 2) F	70	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day,	79ar) 38	Maryl	y)
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	deet deet	Funeral Director	11. Marital Status	12. Was Deceder Armed Force		13.	Was Decedent of I	Hispanic Orig	in? (Specify	Yes or No-		ce - America	
36	or It	by Fu	1 Never Married 2 Marrie	1 ☐ Yes 2X tf Yes, Give	JNo		1 ☐ Yes 2 🛣 No		,	,	Speci	fv:	
Ö	72 hours after deeth with the Maryland Instural, or Iteme 23s or 28s-f ehow Jissi Evantine must be notified at		3 Widowed 4 □ Divorced 15. Decedent*	Year or Dates	s:	16a Dece	dent's Usual Occu	nation		1	6b Kind of F	Whi	
15	n na	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	.5.)	(Give	kind of work done DO NOT use retire	during most	of working		OD. INDIG OF E	74311163341166	istry
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yla	ould Men	2	James Gordo						nces	Wol			
Maryland 21215-0036	d2st thanc t7 is n traun		19a. Informant's Name/Relationsh Lisa Fahey -				ng Address (Street					, State, Zip 0 21076	
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OE .	Pages ent of nt: If i		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp				matory or other pla)4/28/	2009 в	altimo	re, M	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, The Maulcal Examiner must be notified at ODGs.		21. Signature of Funeral Service I	Wen H. Wil	liams	2	remation 299 Frede	issocie erick I	ety of	Maryl Baltim	and, I	nc. D 212	228
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caus	ed the death.							,	Approximate nterval Between
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	/Medical Examiner		resulting in death)		as a conseque				011017				
	-Xaiiiiiei	_	Sequentially list conditions, if any, leading to immediate	b. D.	ing		cev						
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8760,	icate be executed physicien and s the burial-transit	cail		d									
9	death certificate e attending phys od for use as the	Physician/Medical	IF FEMALE:										
Вох	eath certific attending pi for use as t	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal o	death 3	Ectopic pregnanc	;y			1	ate of deliver	/ Day Year
o.	the a	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4∐Pregnant 9∐Unknown		ath 5	Other (specify)			******			
<u>α</u>	that the dened by the a		Part If. Other significant condition	s contributing to death	but not resul	lting in the u	nderlying cause gr	ven in Part I.	-	23e. Did toba	acco use cor	tribute to the	cause of death?
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ž >	Q 5. Z	To	examiner? 1 🗆 Yes 2 🗶 No	Hospital: 1 X npa		R/Outpatier	11 3D 00A		rsing Home	5 ☐ Reside/	nce 6 □Ot	her (Specify)	
	ding P	inol	27. Manner of Death 1 XNatural 5 □ Pending		njury Da <i>y</i> Ye <i>ar</i>)	28b. Time o Injury	Wo			Describe how	w injury occu	rred	
Division	Attending r death. ector: After by the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be 280 Place of	Injuny - At hon	no form et	M 1 creet, factory, office	Yes 2 N		Location (Ste	and Num	her or Rumi	Route Number,
Ď	I or Attend after death Director: I in by the	Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	ile, iailii, sii	eer, ractory, ornce		201.	City or Town,		Der Or Huran	TODIO TVAITOOT,
	Hospite 4 hours Funeral ely fillec	dicai C	29a Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examination	rladge daat on and/or in	h consumed at the t vestigation, in my	imo, Jata and opinion, deat	d place, and th occurred a	due to the na It the time, da	ue (s) and n te and place	and due to t	ted he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen	se number		29	d. Date sign	ed (Month, D	ay, Year)
it.			Vous cilla	Nelson,	MEDICA	AL DOCT	TOR R	es – c	200	1	+PRIL	27	2009
			30. Name and address of person v	no completed cause of	f death (Item	23а) (Туре,	Print)						
			Priscilla Nelson 31. Date filed (Month, Day, Year)	n, M.D., 60	JU Wolf	e Str	eet, Bal	timore	, MD				
	Sta Registr	_	APR 28 2	1009 Serve	on a signal	pa	who						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Leota Painter 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Medica If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 20, 1916 ivista Center 5. Social Security Number 9. Birthplace (State or Foreign Country) West Vriginia 7. Age (In yrs. last birthday) 1□ M 2√ F 214-12-3014 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No VA Page Stanley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1098 Phoebe Lane 22851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify. White Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Zimmerman Elva Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Marie Anderson - Daughter 1105 E. Patuxent Dr. La Plata, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-26-09 Painter Family Cemetery Stanley, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley Funeral Home 187 E. Main St. Luray, Virginia 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LOUIS disease or condition resulting in death) Due to (or as a consequence of): days Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CAD pedension, 1 ☐ Yes 2 ☑ Ho 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinal must be notified at

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical Completed by

attending physician and for use as the burial-transit signed by the a d be detached f cate has been si r, page 2 should b certificate director, death. n 24 hours after death. le Funeral Director: A bletely filled in by the fu

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Certification: To

Medical

29a, Certifier

(Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

24b. Were autopsy findings available prior to completion of cause of death? performed?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

		1 ☐ Yes 2 ☑ No	1 ☐ Yes 2
25. Was case referred to medical examiner?	26. Place of Death (Co	heck only one)	
1 Yes 2 1 No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day, Year) Injury Work?	Describe how injur	y occurred
2 ☐ Accident investigation	M 1 □Yes 2 □No		

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier RANdewal

29d. Date signed (Month, Day, Year)

APril 23rd, 2009.

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scite 101 Waldorf Mp 20602 avinder 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas Poust Noel April 26 2009 12:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 600 Goodman Avenue Dundalk Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 14,1930 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 068-24-8025 11XM 2□ F Months 78 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, In the ceal Experience rust be notified at Director Baltimore Dundalk 1 ☐ Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Goodman Avenue 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other transmit General Manager 12 years 2 years General Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Joseph Poust Katherine Flynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Poust wife 600 Goodman Avenue, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cen. Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. . Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** engestive D MOS disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of): buriat-Physician/Medical the attending properties of the second se IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Christia Rimonan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 □ Yes 2 110 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t' completely filled in by the funera

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

7966 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Point RJ. Baltimore

D396660

29d. Date signed (Month, Day, Year)

MI) 21219

4PM 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician APV) 12715 2009 Bertha Mae Palmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Baltimore Washington Medical Center Ann-1 Shor If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√2 F Days Hours Min. 235-48-3514 75 Virginia Director 11/28/1933 West Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show r than "natural", or items 23a or 28a-f shov the Modical Examiner must be notified at Director 1 □Yes 2\□No Glen Burnie Anne Arundel Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 460 Glen Mar Road United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify þ Specify: White 3 ☐ Widowed 4 ី Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 yrs. Seamstress Upholstery | Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Stuckey Flora L. Benson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William C. Palmer, Jr./Son 58 Stayman Way Littlestown, PA 17340 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/30/2009 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nenmon Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, burial-tran Due to (or as a consequence of) physician the burial led by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print) 3 15017 V

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#20bperFH, G890, 4730709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 e ar April Month Day **Physician** 23. 8:00 PM Edward John Parr, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Frankford Nursing Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06-10-1915 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Mary Tand 93 218-05-6643 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "- any injury or other traumatic event. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 NYYes 2 □ No N/A Directo Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 2714 Erdman Avenue U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 TNo Specify 2 Specify: WII White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Parr Anna McBride ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward J. Parr, Jr. - Son 1022 Boxridge Lane Essex, Maryland 21221 20b. Place of Disposition (Name of More Paride Memor of Descript)

Baltimore National W. Com. 04/29/2009 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jury of Funeral Arvice Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 mele 23a. Part 1. Enter the disease, or complical insithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 4 Unknown 2 No 3 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has trector, page 2 sl autopsy performed? Yes 2 No 1 Yes 2 100 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) lathern Wood Road. change State

Registrar

Davis Thaddeus Reback April 26, 200°9 10 20 20 20 20 20 20 20	1	For State Registrar				Ce	ertificate of	Death	R	eg. No.	009		352
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Alexander Nichael Reback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 19c. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20a. Method of Disposition 10 Burial 22 (Commission 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of commission) or other place) April 27, 20c. Location - City or Town, State 2 20c. Location - City or Town, State 2 20c. Place of Disposition (Name of commission) or other place) April 27, 20c. Location - City or Town, State 2 20c. Place of Disposition (Name of commission) or other place) April 27, 20c. Location - City or Town, State 2 20c. Place of Disposition (Name of commission) or other place) April 27, 20c. Location - City or Town, State 2		17. Father's Na	me (First, Middle, La	st)				18. Mother's Na	me (First, Middle,	Maiden S	Surname)		
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Second Part Other significant conditions Other O				Daughte:									
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that initiated events resulting in death) Last FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 yes 2 yes		4 ☐ Donat 21. Signature 23a. Part 1 dr shook, or	on 5 Other (Spe of Funeral Service Lic ter/the dispesse, or co infart failure. List or une (Tima	censee pomplications that ally one cause on a. rei	Eva a caused the deat each line	th. Do not e	neral Cha 22. Name and Address eaceful A 2325 York nter the mode of dy	pel 20 ress of Facility 1 ternation Road 20 ring, such as cardia	il 27, 009 Ves Funer Timonium,	al&C Mar	Cremati	OII Ct	r. P.
IF FEMALE: 23c. If yes, outcome of pregnancy 1	ner	21. Signature 23a. Part 1 dishops, bilimmedi te Ca disease corresulting in de	on 5 Other (Spe of Funeral Service Lic ter/ine dispase, or con- higher hailbrie. List or the (I ina intion	pensee personal pensee	caused the deat each lin	th. Do not e	neral Cha 22. Name and Address eaceful A 2325 York nter the mode of dy	pel 2 ress of Facility 1 ternati Road ring, such as cardia	il 27, 009 Ves Funer Timonium,	al&C Mar	Cremati	OII Ct	r. P.
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

> State Registrar

29b. Signature and title

6

29d. Date signed (Month, Day, Year)

568

Ra Ha

m 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 40am 2009 Betty L. Reynolds /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death City, Examiner If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 5/15/1927 n/a Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 81 Virginia West Director 235-40-4171 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1√2Yes 2□No n/a Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2608 Cole Street 21223 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Ye ar or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker 0 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Kerns Lila unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Henry R. Reynolds /husband 7725 Colonial Street, Pasadena, Maryland 21122
ace of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/24/2009 | Baltimore, Maryia Miy Hubbard Funeral Home, Inc. 4 Departion 5 NOther (Specify) entombment Loudon Park Baltimore, Maryland 21. Ignatur of Funeral Service Licenses 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3/n/n **Physician** 10 Cardi /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Yes 2 DN6 is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eynolds De71y -Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 400 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ten Avenue Baltimore MD 21229

17

State Registrar

DHMH 17 Rev 1/2001

APR 28 2009

31. Date filed (Month, Day,

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 14 700° Month **Physician** Ε. Reed Alice Ori /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore <u>Seasons Hospice @ Northwest</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Social Security Number Funeral Hours Months Davs 1 □ M 2 🛣 F 372-20-1920 Jun 9 1920 Michigan Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ther traumatic event, the Medical Examiner must be notified at MD Baltimore Gwynn Oak 1 ☐ Yes 2 XNo Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 USA 1203 Ingleside Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █️No 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Shu1z John В. Buehrer Anna ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troops. 1203 Ingleside Avenue, Gwynn Oak, MD Don Reed - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 04/28/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD Williams 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Cardiac Disease /Medical Due to (or as a nsequence of): Examiner Hortic Stenos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Renal Falluro 1 Yes 2 No 3 Probably 4 Unknown Completed the at luberculasi 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No COPID 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue U666 31. Date filed (Month, Day, Year) APR 28 2009

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary	,	epariment o Certificate d			-	giene Reg. No.	2009	13523
		ę	Registrar 1. Decedent's Name (First, Middle, L.)	ast)					2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		Fern Louise	Ramsey					April	24,	2009	2:00 P ^M
3	Examin		4a. Facility Name (If not institution, g			4b. City, Tow		ion of Death			County of Deatl	
,			Laurel Regional 5. Social Security Number 6.		In yrs. last birth	Laure		nder 24 Hrs.	8. Date of Bir	th	ince Ge	orge s place (State or Foreign untry)
	Funeral Director		568-38-2158	1 M 2 TXF	-	rs. Months Da	ys Hou	urs Min.	(Month, Da		919 Co	intry) 1orado
	DU. >	Usual Residence of Decedent										10d. Inside City Limits
	f shov	ō			Laurel							1 □Yes 2 🔂 No
-	28a-	rect	MD Prince 10e. Street and Number	George 5	Laurer	10f. Zip Coo	de			10g. Citi:	zen of What Co	untry?
1	23a ol	Funeral Director	12805 Fernwood	Turn		20708	8			US	A	
	r dear	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent If Yes, specify (of Hispani Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.))-	 Race - Amer Black, White 	
9	rs affe	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	I ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No <i>Sp</i> e	ecify:			Specify: Whi	te
0000-	z should be hied within 12 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ted t	15. Decedent's	Education	16a. I	Decedent's Usual Od (Give kind of work de	cupation	most of worki	ina	16b. Ki	nd of Business/l	ndustry
2	iffilin / ne. nan "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work do life. DO NOT use re	etired)	most or work	ng		Medica1	
7	Hed W		12 17. Father's Name (<i>First, Middle, La</i>	4		Nurse	18. N	Nother's Name	(First, Middle			
yland	d be 1 ental l ced ot c evel	o Be	Fred H. Johnson	•					len Bre		,	
֝֟֝֟֝֟֝ <u>֟</u>	shoul nd Me mark umati	To	19a. Informant's Name/Relationship		19b.	Mailing Address (St	reet and N	umber or Rura	al Route Numb	er, City o	r Town, State, 2	Tip Code)
, Ma	and 2 salth a 27 Is er trai	- 8	Ellen Eldridge/	Daughter	12	805 Fernw	ood T				20708	
ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial _ 2 ☐ Cremation 3	Removal from State	20b. Place of cemeters	Disposition (Name of crematory or other	f place)		Date	20c. Lo	cation - City or	Town, State
Dailimor	t. Pac rtmen rtant: njury		4 □ Donation 5 □ Other (Spe 21. Sign ure of Fureral Service Lic	cify)	Cemete	ery		4/30			ison, T	N eral Home
ם D	Depa Impo any i		21. Sign fure of Funeral Service Lik			509 Wal						37172
М			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	e death. Do n	ot enter the mode of	dying, suc	ch as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
F	hysician	6 1 1	Immediate Cause (Final disease or condition	Vrosepa								Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Myocardial infarction									
	-xummer	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c								days
7	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Atrial	fibril	lation						days
, 5	an an	Exa	resulting in death) Last	Due to (or as a c	•							
00/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		d. Congest	tive he	eart failu	re					years
×	certific	/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy						23d. Date of del	iverv
Ď.	death e atten ed for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐Live birth 2 [4 ☐ Pregnant at tin		3 ☐ Ectopic pregn 5 ☐ Other (specif					Month	Day Year
ָ כ	at the by the tacher	hys	9 Unknown	9□Unknown					1			
Ś	requires that the een signed by th nould be detache	þ	Part II. Other significant condition	-	not resulting in	the underlying cause	e given in I	Part I.				the cause of death?
cords	requi	eted	Respiratory in	sufficiency								
Ō.	The law te has b	Completed								opsy ormed?	prior to death?	topsy findings available completion of cause of
	an: T tificate tor, pa	မ င်	25. Was case referred to medical				26.	Place of Deat	l 1 Yes h Check onl		1 ∐ Yes	2⊠ No
5	nysicia nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient	2 □ ER/Out	patient 3 DOA	Other: 4	☐ Nursing Ho	me 5□Res	idence	6 □Other (Spe	cify)
n or	ding Physician: The lav n. Affer this certificate has funeral director, page 2		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y			Injury at Work?		28d. Describe	how inju	ry occurred	
UNISION	ottend death, ctor: / the f	icati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 28e Place of injury	/ - At home, far	m, street, factory, of	1 ☐ Yes	2 🗆 NO	28f. Location	(Street ar	nd Number or Ri	ural Route Number,
2	after after Direction by	Certification:	4 ☐ Homicide determin	ed building, etc. (,,		1	City or To	wn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it		29a. Certifier 1 😾 Certifying	Physician: To the best of examiner: On the basis of ex	my knowledge	, death occurred at t	he time, da	ate and place,	and due to the	e cause(s) and manner as d place, and due	s stated. e to the cause(s)
	the H hin 24 the F mplete	Medical	one)	and manner state		_	cense num				te signed (Mont	
	P N N		29b. Signature and title of certifier	a Dolla			7,90	123		L	1/24/	109
	3		30. Name and address of person w	ho completed cause of the	ith (Item 23a), (Type, Print)	<i>U</i> .	.00	had		1311	
			1350 Van	Just (d 4	320 6	an	ul,	NUM	10	1"	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registřar's	12	hadel		,				

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

4111 Lower

Registrar's Signature

Beckleysville Road

Hampstead Maryland 21074

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deogra cias V.

31. Date filed (Month, Day, Year)

raustino. m.o.

Division or Vital Records, P.O. Box 68760,

09-03362

REPlease Type or Partin Black Indelible Ink. Ensure All Copies Are Legible.

lward Rutter, Jr		State of Maryland / Departmo 1- For State Certifica Registrar				2009	13525		
Physicia	n/	Decedent's Name (First, Middle,Last)			Date of Death Month	Dav Year	3. Time of Death 1736 hrs		
edical Examin		Edward Rutter, Jr. 4a. Facility Name (if not institution, give street and number)	- 4	4b. City, Town, or Location of Death	April 26, 20	4c. County of Deat			
		103 South Bend Court		Glen Burnie		Anne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birting 413-58-5728 1 M 2 F 71	nday) Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min.			rthplace (State or Foreign buntry) TN		
any	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Locati	on			10d. Inside City Limits		
* .		MD Anne Arundel Glen					1 Yes 2 X No		
farylan 28a-f s	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?		
death with the Maryland or items 23a or 28a-f show must be notified at once.		103 South Bend Road		21060		United St			
ath with	nera	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	13. Wa:	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,		
fter de:	by Funeral	X 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer	1	Yes 2 No specify:		Specify: V	Vhite		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once	호 당			t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		16b. Kind of Business	/Industry		
36 in 72 h han "r dical F	Bet	Elementary/Secondary (0-12) College (1-4 or 5+)				77 1			
d with	Completed	17. Father's Name (First, Middle, Last)	EL	ectrical Enginee 18.Mother's Name		Westingl aiden Surname)	<u>iouse</u>		
1215 I be filk ental H urked vent, t	Be	Edward Jackson Rutter, Sr.		Adelai		fel			
D 2'should and Manic e	۱٩			Address (Street and Number or F					
Baltimore, MD 21215-0036 ocmit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica	1	20a. Method of Disposition 20b. Place of	f Dispos	Broad Branch Way	Date	20c. Location - City o	21704 r Town, State		
MOF Pages ent of nt: If		Durial 2 2 Cremation 5 Removal from State		ner place) Crematory 5/0	2/2009	Glen Burr	nie MD		
Salti ermit. epartm nporta jury o	ı	21. Signature of Funeral Service Licensee	22. N			Funeral &			
	4	23a. Part I. Enter the disease, or common that caused the death. Do no	Se:	rvices PA, 1 2nd	Ave SW	Glen Burr	Approximate Interval		
Physician /Medical		failure. List only one cause on each line.					Between Onset and Death		
Examiner		or condition resulting in death) Due to (or as a consequence of):			7	1.5			
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Hypertensive ath Due to (or as a consequence of):	eros	sclerotic cardio	Vascular	disease	-		
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uted nd ransit	<u>~</u>	d				0			
60, ate be executed hysician and te burial - transit	dica	Xunpended Amended PI line a-	b, E	?11,27,perME, g8	92 6/3/0	9 11			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial_trans		IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth		tal death 3 Ectopic pregna	ancv	23d. Date of deliver	ry Day Year		
Box 68 E death cert the attendir	sicia	past 12 months?	_	her (Specify)			.,		
0 + 8		Part II. Other significant conditions contributing to death but not resulting	g in the u	inderlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?		
P.C es that igned be deta	2	_Diabetes mellitus			1 Yes	2 No 3 Pro	bably 4 🗸 Unknown		
ords,	ete				24a. Was a		utopsy findings available completion of cause of		
See place of Death (Check only one) 24a. Was an autopsy performed? 1 ✓ Yes 2 No 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28d. Describe how injury							es 2 No		
Vital F ysician: ' his certific director, I	Bec	only one)	r-n						
of Vi ing Physi After this	۵	examiner / 1		Residence 6 Othe	er; Scene				
ट ≒ _ ^ द	틽	Natural 5 Pending		1 Yes 2 No					
Division tall or Attendi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	ırm, stree	et, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City		
Dispital hours a meral y filled	Ser	4 Homicide determined (Specify) 29a. Certifier A Continue Description To the house of expressions determined							
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in	ath occur nvestigat	red at the time, date and place, and tion, in my opinion, death occurred a	due to the cause at the time, date a	e(s) and manner as sta and place, and due to t	itea. he cause(s)		
To To	Me	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	onth, Day, Year)		
	Mlm Branell MD O.C.M.E. April 30, 2009								
OCME	Ì	30. Nam, and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	111 P	enn Street, Baltimore, MD	21201				
Dending	ate	31. Date filed (Month Day, Year) 32. Jegistrar's Signature		Jan State St					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2009 6:00 A M Shanahan Hileen Eleanor わいい જુ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner S. Main St Hampstead If Under 1 Year | If Under 24 F acroll 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 1 F 14,1930 Director 100-22-3480 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or death with USA Funeral items Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itel any injury or other traumatic event, its Medical Exaction once. Black, White, etc. 1 ☐ Yes 2 NHO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No \$ Specify 3 ☐ Widowed 4 Divorced Whi Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Donnes 19 cme ma Ker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Hileen Horace armita con 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa t's Name/Relationship (Type. Print) lerrance sallie & Shanahon Main St Hampstead 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-30-09 _5. ☐ Other (Specify) Crematory 4 Donation 21. Signature of Tuny al Service License ILAM 1232 Midvalle ranch Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part I. Et shock Immediate Cause (Final disease / r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.

within 24 hours after death.

The Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for the former of the funeral director, page 2 should be detached for the funeral director. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

700A

Pade Rd UFSDAINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Year Month Louise Gibb Scott 04 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Franklin Square Hospital 5. Social Security Number 6. Sex 7. Ag se Baltimore 8. Date of Birth 0 7 2 4 7 1 9 1 9 Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F 214-24-4088 89 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Parkville Baltimore MD 1 ☐Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 3114 Texas Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Obed C. Gibb Emily Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 E. Joppa Rd. Apt. 708, Towson, MD 21286 June Scott-Landon/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Moreland Memorial 04/28/09 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Park 22. Name and Address of Facility Evans Funeral Chapel & 8800 Harford Rd. Parkvi 23a Par II Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (I had disease or condition resulting in death) a. Do not enter the mode of dying, such as cardiac or respiratory arrest, and disease or condition resulting in death) Parkville, MD 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 🗆 Live birth 2 🗆 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 MNo 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

executed

certificate be

The law requires that

Hospital or Attending Physician:

Box 68760.

P.O.

of Vital Records,

Division

injury or other traumatic

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

Physician

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

Be

and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be todified at

 $C \circ ff = LOU \mid SC \mid G$ Timore, Maryland 21215-0036

/Medical

burial-tran and attending physician for use as the buria been signed by the should be detached has this certificate

Physician/Medical \$ Be 2

Examiner Completed To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification:

☐Yes 2 No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a, Certifier

Medical

State Registrar

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐Yes 2 ☐ No

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number 3 29d. Date signed (Month, Day, Year) 4(24(09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) APR 28 2009

32. Registrar's

9000 Franklin Square Drive Baltimore, MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	† Marylai		artment of F <i>rtificate of I</i>			giene Reg. No. 2 N N C	13528
	Physicia	an	1. Decedent's Name (First, Mid		mith				2. Date of Dea Month	ath	3. Time of Death
	/Medic	al	4a. Facility Name (If not institut)	4h City Town or	Location of Death	4	Day Year 3 5 0 6	
1	Examin	er	St. Elizabeth	on, give sireer and nor	inder)		Baltim			n/a	
	Funeral		5. Social Security Number	6. Sex		(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				v, Year) C	rthplace (State or Foreign ountry)
	Director		213–16–5289 Usual Residence of Decedent		87				3/29/1	922 Mai	ryland
	show	_	10a. State 10b. Coun	ty		ity, Town or Lo					10d. Inside City Limits 1√2 Yes 2 □ No
	the Ma	Director	MD n/a		Ba	ltimore	10f. Zip Code			10g. Citizen of What C	21
	3a or		3300 Benson Av	venue			21227			USA	,
	r deatl	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whi	
36	fled within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Madical Eventral must be prolified at	by F	1 ☐ Never Married 2 ☐ Married	If Yes, Giv	ve -	1	1□Yes 2 <mark>X</mark> No	Specify:			White
2-0	72 hou natura lical E		15. Deced	ent's Education hest grade completed)		16a. Dece	dent's Usual Occup	ation during most of work	ina I	16b. Kind of Business	s/Industry
Maryland 21215-0036	vithin 7	Completed	Elementary/Secondary (0-12)		I-4or 5+)	life.	DO NOT use retired	i)	9	Retail	
<u>م</u>	filed v I Hygie other t ent, th	Be Co	17. Father's Name (First, Middl	e, Last)		Super	LVISOI	18. Mother's Name	e (First, Middle,	Maiden Surname)	
/lan	uld be Mental arked o	To B	Harry Smith					Louise R	ausch		
Jan	12 sho h and 7 is ma rauma		19a. Informant's Name/Relatio		. 4		-			er, City or Town, State,	
ē,	1 and Healt tem 2		Darlene Jacobs 20a. Method of Disposition	son / Daugr			WETTINGCO position (Name of matory or other place		warren Date	ton, VA 20	
altimore,	Pages nent of int: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State		matory or other place Faith Cem		/2009	Baltimore	, Maryland
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Eventires must be notified at once.		21. Signature of Funeral Service	ce Licensee	1					uneral Home	•
	TO = 60 0		23a. Part 1. Inter the disease,	or complications that c	aused the dea						vland 21229 Approximate
	Physician		shock, or heart failure. Li Immediate Cause (Final disease or condition	ist only one cause on e	each line.	car					Interval Between Onset and Death
	/Medical		resulting in death)	a	(or as a conse						
	Examiner	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a conse	equence of):					
	cuted ansit	Examiner	that initiated events	4		,					
90,	ificate be executed physician and is the burial-transit		resulting in death) Last	Due to	(or as a conse	quence of):					
68760,	ficate I physics from the b	edical		d							
_	leath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregi		☐ Ectopic pregnanc	v		23d. Date of d	
P.O. Box	The law requires that the death cert are has been signed by the attending agge 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time of		Other (specify)	,		Month	Day Year
	w requires that the d been signed by the should be detached		Part II. Other significant cond	itions contributing to de	eath but not re	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	en sign	ed by							1 🗆 '	Yes 2 No 3 1	Probably 4 Unknown
ဝင္ပ	faw re nas be	Completed							24a. Was	osv l prior to	autopsy findings available ocompletion of cause of
a H	Physician: The la this certificate ha		05 W						1 ☐ Yes		s 2 🗆 No
\equiv	ysicia is certi directo	o Be	25. Was case referred to medie examiner? 1 ☐ Yes 2 ☐ No	Hospital	Inpatient 2[☐ ER/Outpatie	nt 3 □ DOA Oth	er: 4 V Nursing Ho		<i>ine)</i> dence 6 □Other <i>(Sp</i>	ecify)
0 L	ding Ph h. After th funeral	On: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date (Mon	of Injury oth, Day, Year)	28b. Time o	Worl	y at k?		now injury occurred	
Division of Vital Records,	ttendi death. stor: A / the fu	icati	2 Accident inves	stigation	of Injury - At	home farm st	M	Yes 2 □No	28f Location (Street and Number or I	Rural Route Number
<u>≤</u>	al or Atten s after deat il Director: ed in by the	Certification: To	4 ☐ Homicide dete	rmined 200. Place buildi	ing, etc. (Spec	oify)	,,,		City or To	vn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p.	Medical (ying Physician: To the							
	To the within 7 To the Somple	Mec	29b. Signature and title of certi	fier			29c. Licens	-		29d. Date signed (Mor	nth, Day, Year)
			· a	- CRNA	<i>-</i>		RII	1615		419710	09
			30. Name and address of person Jennifer	Galdsho	mich	333	O Beas	on Ave.	Balt	more, H.	0 21227
	Sta	te	31. Date filed (Month, Day, Yea	ar) 32. F	Registrar's Sign	nature	1.1	-			
	Registr	ar	ADD 989	nna Bruss	M B.	gar					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{A}^{M} 2009 1:19 April 24. Ethel Southwick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Woodstock 2100 Ganton Green #101 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Min 1 □ M 2 🕱 F July 25, 1925 Maryland 83 Director 213-20-6762 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercitivit must be a cultified at 1 ☐ Yes 2X No Woodstock Director MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21163 10801 Endfield Drive, Apt 315 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify.**White** Specify ð 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins 12 Communications Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill the and Mental H 7 is marked oth Be Josephine Corcoran Andrew Helfer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2100 Ganton Green #101 Woodstock, MD 21163 Frances Hollon/daughter Health a permit. Pages 1 and Department of Heal Important: If item 2 any injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/24/09 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 Locked 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician aro o pu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trai be execu Due to (or as a consequence of) physician Box 68760 Physician/Medical the l as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown signed by to ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Daughter's examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

| Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of person who com leted cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 3:00a Henry E. Smith Apr 26, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Baltimore Randallstown Seasons Hospice -Northwest Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min 1 → M 2 □ F Months Days Director 216-34-0817 Aug 12, 1938 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, I'm Multical Examinat rust be notified at Director 1 X Yes 2 □ No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2722 Carver Road 21225 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1955 1 ☐Yes 2 No þ Specify 3 Widowed 4 Divorced Black Year or Dates 1957 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Frances Jackson Pearlie Smith ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Carver Road Baltimore, Maryland 21225 Rosetta Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/07/09 4 ☐ Donation, 15 ☐ Other (Specify) Owings Mills, Md. Garrison Forest Veterans Cemetery Souther Frneral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 2121
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Conc disease or condition MAG resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical attending p for use as use as IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Soknown Completed 24b. Were autopsy findings available prior to completion of cause of death? las autopsy certificate 1 ☐ Yes 2 No 1 □Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 22500 6 Nother (Specify) Inpt - hospice 1 ☐ Yes this (Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending investigation I Director: / 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours a 29a. Certifier ertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinter 21136 Million 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Apest 15:40 M SIEBERT JR **Physician** 21 2009 WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 125 Breakwater Court Joppa 8. Date of Birth (Month, Day, Year)
Nov. 15, 1930 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number Davs Hours Min. **Funeral** 1**X** M 2□ F 78 MD 216-24-5493 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or no once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b Count 1 □Yes 2 XNo Harford Joppa MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 125 Breakwater Court 21085 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Armed Forces 1 Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Black White etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Continental Can College (1-4or 5+) Elementary/Secondary (0-12) Supervisor 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Dembeck William H. Siebert ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 125 Breakwater Court Joppa MD 21085 Karen L. Siebert /wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Penn Lincoln Memorial 4/27/09N. Huntington PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD 21. Signature of Finera Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1 Enter the disease, or com shock, or heart failure. List on dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS PULMONARY **Physician** /Medical Due to (or as a consequence of): Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending pl yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the s Ö 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RHEUMATOLD ARTHRITIS page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE 24a. Was an autopsy performed? 1 Yes 2 KNo aw has 2 No 1 ☐ Yes this certificate Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death After t Certification: 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar DANIEUE 2 8 2009

6565 N CHARLES ST, SUITE-209 BALTIMORE, MD 21204 DOBERMAN, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64395

APRIL 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #12, perFH g891 5/15/09 Tertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Sel , ama, 2 2000 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Cente 9 University of Maryand 8. Date of Birth (Month, Day, Year)
July 4, 1933 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 Ø M 2□ F Months Days Hours Min 214-30-3463 75 MD Director Usual Residence of Decedent show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, It a Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7810 Overhill Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 4 es 2 100 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Environmental Elements Elementary/Secondary (0-12) College (1-4or 5+) Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton T. Seligman Catherine V. Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan Seligman/ Wife 7810 Overhill Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Crownsville, MD Maryland Vets. Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Scanne Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Servcies PA 1 2nd Ave. SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** a consequence of) hr /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Display for as a consequence of requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been si e 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed? Ves 2 No page certificate 1 ☐ Yes 2 ☐ No Physician; After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day, Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

APR 28 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** 6:11AM 24, April Ricky A. Sponaugle, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Oct 20, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 216-80-6273 1961 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f shov If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 1704 Saunders Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 TNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any lajury or other traumatic event, the Maonee. Elementary/Secondary (0-12) College (1-4or 5+) Document Agent 12 Fed Ex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sponaugle Wanda Everett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Sponaugle / Wife 1704 Saunders Way Glen Burnie, MD 21061 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signatur of Funeral Selvina Line see 22. Name and Address of Facility Singleton Funeral and Cremation 2nd Ave SW, M01220 Services 1 Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician 🧏 /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I∐Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death our not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autops, performed? certificate ha 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X ER/Outpatient 3 DOA 1 Inpatient Certification: To After thi funeral 27. Manner of Death 1 ★ Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

| Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in To the Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) State Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

penavyle, hicky

10/20/61

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ESTINE 3009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OURS HOSPITA 24 Hrs. 8. Date of Birth Min. (Month, Day 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗷 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaning must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 □ No Be Completed by Funeral Director Itimo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11+4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ a 19b. Mailing Addre's (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 01 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service in 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final disease or condition resulting in death) **Physician** Suspected /Medical Due to (or as a consequence of): Examiner Respirators Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown Hypeatons.on 1 ☐ Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No autopsy 1 ☐ Yes CORDNAY To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director, I 25. Was case referred to medice examiner?
12 Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

CYNTH: A 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

DO Bon Secours 32. Registrar's Signature

DD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shen

29c. License number

HOO 62554

HOSP.TAL

29d. Date signed (Month, Day, Year)

2000

Baltimore

04-24-2009

Balt. more

STreeT

21223

MARdrellA GLENDORA SMITH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03090 State of Maryland / Department of Health and Mental Hygiene JNK UNK Certificate of Death 1- For State 2. Date of Death tegistrar Decedent's Name (First, Middle,Last) Month Day April 18, 2009 0135 hrs Physician/ Mardrella Glendora Smith Me₹ xaminer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** 1429 North Broadway If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) Foreign MD 5. Social Security Number Min. 10/30/51 **Funeral** Hours 57 214-56-4650 Yrs Director M 2 XF 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State MD 10b. County N/A 1 X Yes 2 No Baltimore 28a-f shov 23a or 28a-f show 10g. Citizen of What Country? 10f. Zip Code Director 10e. Street and Number 21205 USA 1429 N. Broadway 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status WAIFFican or items Armed Forces? 1 Never Married 2 Married 2 X No Specify:American Yes Yes 2 X No specify: Divorced If Yes, Give Year 3 X Widowed 16b. Kind of Business/Industry Examiner 16a. Decedent's Usual Occupation (Give kind of work done ≥ 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours a
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura
injury or other traumatic event, the <u>Medical Exami</u> during most of working life. DO NOT use retired) Construction Completed College (1-4 or 5+) Elementary/Secondary (0-12) Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Jennings Reginald Addison Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21215 (balt.) 3439 Reistertown, MD Ida Swilling/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Balt., MD 9/24/09 Bayview Crem. Other Specify Donation 5 22. Name and Address of FacilityHari P. Close F. 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and vsician Death failure. List only one cause on each line Smoke inhalation and thermal injuries ledica' Immediate Cause (Final disease Examine Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED 23a,27,28a-f per me g891 5-1-09 vt Physician/Medical X UNPENDED physician the burial -23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy Year IF FEMALE Day Ectopic pregnancy Month Fetal death 23b. Was decedent pregnant in the icate has been signed by the attending page 2 should be detached for use as I past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions No 3 Probably 4 V Unknown Division of Vital Records, P.O. Yes 2 δ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy death? performed? No 2 1 V Yes ✔ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director. Nursing Home 5 Residence 6 Other: Scene Be Other₄ examiner? Hospital: 1 FR/Outpatient 3 Inpatient 2 this 28d. Describe how injury occurred 1 Yes ၉ 28c. Injury at Work? 28h. Time of Injury fineral 28a. Date of Injury 27. Manner of Death After Certification: 1 Yes 2X No victim of house fire within 24 hours area C. To the Funeral Director: Al 1 Natural Pending 1:35a 4-18-09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1429 North Broadway 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide Baltimore, Maryland determined (Specify) house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) dical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 18, 2009 O.C.M.E. o completed cause of death (Item 23a) 30. Name and address of person w 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Jack Titus MD.

31. Date filed (Month, Day, Year)

ORIGINAL

egistrar's Signatur

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland				Mental Hy	giene		
	-		Registrar		Cer	tificate of L	Jeath 		Reg. No. 2	19, 13536	
	Physici		1. Decedent's Name (First, Middle, Last) Mary J. Strickle	r				2. Date of Dea	11, Day 2009 Ye	3. Time of Death 4:00 PM M	
	/Medio Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	4c. County of E			
1			113 W. Martin St	reet		Snow Hi			Worcester		
	Funeral		5. Social Security Number 6. Sex 1 Number 1 Number 6. Sex	7. Age (In yrs. las	st birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	Λ / 4				May 17	, 1934	New York	
	yland		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits	
	Ba-fs	cto	MD Worceste	r Sno	w Hil					1 X Yes 2 □ No	
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?	
	ns 23	eral	113 West Martin St	Was Decedent Ever in U.S.	13. V	21863 Vas Decedent of Hi		pecify Yes or No	USA 14. Race - A	American Indian,	
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examine must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	"	Yes, specify Cuba □Yes 2ሺNo	n, Mexican, Puert	o Rican, etc.)	Black, V Specify:	Vhite, etc.	
2-0	natura lical	eted	15. Decedent's Educat (Specify only highest grade co			lent's Usual Occupa		kina	16b. Kind of Busin	ess/Industry	
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	ung	unknow	n	
2	iled w Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	4	1e	acher	18. Mother's Nan	ne (First, Middle,	Maiden Surname)		
lan(ild be f Aental rked o	To Be	Harold Francis Arm	brust Jarvis			Grace		,		
Maryland	nd 2 shoualth and N 27 is mai		19a. Informant's Name/Relationship (Type. Charles Strickler	Print) Spouse		g Address <i>(Street a</i> West Mair			er, City or Town, Sta	ite, Zip Code) 21863	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☑ Donation 5 ☐ Other (Specify)	20b. Pla	ce of Dispo metery, cren	sition (Name of natory or other plac	е)	Date	20c. Location - City	y or Town, State	
Balti	permit. Departr Importa any inju		21. Signature of Funer Service Licensee Wade,	Director	1	Name and Addres	. 5	tate Ana e St, Ba	atomy Boar altimore,	d MD 21201	
			23a. Party. Enter the disease or complicate shock or heart failure. List only one	tions that caused the death.	Do not ente	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between	
Sanny.	Physician		Immediate Cause (Final disease or condition	Chauss conseque	. 06	struction	a Pula	LURRRY	Descesa	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):			1	2.7		
	4	e	Sequentially list conditions, b.	Due to (ones a conseque	rine (d):						
	cuted id ansit	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ó	e exe ian ar ırial-tr	Exa	resulting in death) Last	Due to (or as a conseque	nce of):						
8760,	icate be executed physician and the burial-transit	dical	d								
9 X	eath certific attending p	/Me	IF FEMALE: 23c	. If yes, outcome of pregnan	cv				23d. Date o	fidaliyary	
Box	The law requires that the death certifi ste has been signed by the attending age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)	у		Month	Day Year	
P.O.	that the de ned by the a detached t	hys	9 🗆 Unknown	9 ☐ Unknown				211			
ds,	ires th signed	by	Part II. Other significant conditions contri	buting to death but not result	ing in the ur	iderlying cause give	en in Part I.			te to the cause of death? ☐ Probably 4 ☐ Unknown	
Sor	w requir been s should	etec									
Be	The law te has age 2 s	Completed	100000000000000000000000000000000000000						prior prior dea	re autopsy findings available r to completion of cause of th? Yes 2 No	
ital	lan; Triffica rtor, p	o l	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o		res 2 🗆 No	
<u>></u>	Physician; r this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 □ DOA Othe	er: 4 □ Nursing H	ome 5 Resi	dence 6 Other	(Specify)	
Division of Vital Records,	anding P ath. or: After t	ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	28c. Injury at Work? 28d. Describe how injury occurred				
DİVİ	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (. City or To		or Rural Route Number,	
	Hosp. 24 hou Funer etely fill	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Medical Examiner	ian: To the best of my know r: On the basis of examination and manner stated.	ledge, death on and/or in	n occurred at the tirvestigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)	
	To the within To the Somple	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (A	Month, Day, Year)		
			C. Erwert Gu	uis Ir aus.		000	06325	3	4-11	. 09	
			30. Name and address of person who comp	pleted cause of death (Item 2	23a) (Type,	Print)				1	
			C. Englest Gill	5 Ja M. J.	10	Szaw H	ill, M	0218	63		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2.8 2009	12 Hegistrar's Signatu	. 100	wed					

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SUSIE ISABEL SUDDERTH 20:20 PM 2001 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL N/A BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10-21-1908 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Days Hours MARYLAND 218-22-1648 100 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 N. FULTON AVE. 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ZMNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No ģ Specify: Specify: 3 XWidowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Meonce. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ OLIVER T. MURDOCK MARY_HOLMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRI POLKARD(GRANDDAUGHTER) 532 N. FULTON AVE. BALTIMORE, MARYLAND 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2/ Cremation 3 Removal from State CEDAR HILL CEMETERY 4-27-2009 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature f Furreral Service Licensee 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease r condition resulting in death) **Physician** HULTILOBAL PNEUHONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any earling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AGRTIC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has t lirector, page 2 si 24a. Was an 1 ☐ Yes 2 **M**0 : After this certific stuneral director, 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗐 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred atural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerai I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOO 04121/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANIN WASSEM 6000 SAHURETAN HOSPITAL SGOIL OCH RAVEN BLUD , BALTIMORE, MD, 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3539 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20<u>09</u> Month **Physician** Tayloe Dorothy 23. 11:20 pM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manchester Carrol1 Long View Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours Director Jan 21, North Carolina 243-34-3075 80 1929 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examination in the confided at Director PA 1 ☐ Yes 2 ☑ No Hanover York 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 361 Barberry Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) 12 Secretary Lega1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jackson Julius Moore Georgia Mae Durham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward T. Tayloe Husband 361 Barberry Drive Hanover PA17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □xBurial 2 □ Cremation 3 □ Removal from State 4/27/09 4 □ Donation 5 □ Other (Specify) Pikesville, Maryland Druid Ridge Cem 21. Signature of Funglal Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease shock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical the as nse yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 0 Month 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypothysoidism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 □ Yes 2 No 1 Tes Hospital or Attending Physician: this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 □Yes 2 □ No n 24 hours after death.

e Funeral Director: A pletely filled in by the fi 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the within 2

State Registrar 31. Date filed (Month, Day, Year) APR 28 2009

29b. Signature and title of certifier

Of unswiper, MI)

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIER 349 Molcolm DR, Westminster,

29c. License number

51705

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2009 April 20, 12:30 PM Gordon Thomas **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Catonsville Baltimore 225 Glenrae Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar. | Mar. | 4, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral A1abama 1 **5** M 2 □ F 87 421-03-7519 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examinar must be nothined at 1 Yes 2 No Director Catonsville MD Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 225 Glenrae Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 NYes 2 ☐ If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married White 1 □Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other fraumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Boatsmen Mate - Chief U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie B. Caudle William Gordon Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
225 Glenrae Drive, Catonsville, MD 21228 19a. Informant's Name/Relationship (Type. Print) Edith Thomas - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of certificity, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4-24-2009 Baltimore, Maryland Ā ☐ Other (Specify) 4 □ conation 22. Time and Address of Facility Ambrose Funeral Home, Inc. neral Service Licer see 1328 Sulphur Spring Rd., Arbutus, MD 21227 Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final MONTHS **Physician** disease or condition resulting in death) /Medical TATIC LIVE & DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I I Inknown 9 ☐ Unknown 23e. Did tobacco use conflibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 Tes Completed 34b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 ☑ No certificate 25. Was case referred medical examiner? 26. Place of Death (Check only ope) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 < Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) TENDING 29b. Signature and title of certifie

State Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 354 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Пау Month Year **Physician** 5:00 P M RAYMOND JOHN TRAVIS APR. 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford <u>914 Bernadette Drive</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Dec. 10, 7. Age (In vrs. last birthday) 5. Social Security Number Year) 1936 Maryland **Funeral** Min. Hours Months Days 1**⊠** M 2□ F Director 212-36-8131 72 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a, State show ir than "natural", or Items 23a or 28a-f shov 1 ☐ Yes 2 X No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21050 914 Bernadette Drive by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) nt of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, Item Item Paper Products Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Dippel Raymond Robert Travis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 914 Bernadette Dr., Forest Hill, Maryland 21050 Roberta Jean Travis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important; If It any Injury or o 3 □ R émoval fré 4-27-09 Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Spryce/Lice 1317 Cokesbury Road, Abingdon, Maryland 21009 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or at a conse juenc j or) /Medical Examiner Exquentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ∐ No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 HO 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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State Registrar

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(Check only one)

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Year.

death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Evertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Joseph A. Uhlhorn 25, 2009 11:45 A^M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Assisted Living Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 □ F Director Dec.2, 1913 <u> 212-07-2394</u> Maryland Usual Residence of Decedent with the Maryland show. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Experience must be notified at Director Maryland Baltimore Catonsville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21228 USA 12 North Morerick Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or ite 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 2 📉 No 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐Yes 2 No Specify: \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Balto. City Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Uhlhorn Margaret Arnold ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other traces 12 North Morerick Avenue; Catonsville, MD 21228 JoAnn Karpers Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 4/29/2009 | Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Linens 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rulmana. disease or condition resulting in death) /Medical Que to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner s a consequence of): use as the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by the ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? certificate of Vital 1 ☐Yes 2 ☐No 1 □Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Assisted 1∐ Yes Hospital: 2 3 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Division 5 ☐ Pending investigation death. 1 ☐ Yes neral Director; A 2 / Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar
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duress of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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31. Date filed (Month, Day, Year)

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	-	State Registrar	,	ificate of Death	Reg	1.No2009 13543		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Mary E. Vogel			2. Date of Death Month April 27	Day Year 2:55 A M		
Examin		4a. Facility Name (If not institution, give street and nu Keswick	mber)	b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director		5. Social Security Number 6. Sex 1 M 2574F		If Under 1 Year If Under 24 Hrs. Vonths Days Hours Min.	8. Date of Birth (Month, Day, 1)	9. Birthplace (State or Foreign Country)		
D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	tion		10d. Inside City Limits		
he Mary 28a-f sh	Director	MD Baltimore 10e. Street and Number	Towson	10f. Zip Code	100	1 ☐ Yes 2 🗓 No		
th with t		1207 Culvert Road		21286		JSA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them Z7 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Medical Examiner must be nutified at once.	Funeral	11. Marital Status 12. Was Deci Armed Fc 1 Never Married 2 Married 1 Yes, Gi	orces? If Y	as Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto ☐Yes 2 ☑No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
2 hours atural",	ted by	3 LXWidowed 4 □ Divorced Year or D	ates: 16a. Deceder	nt's Usual Occupation		Sb. Kind of Business/Industry		
within 72 iene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (**2*** 2	life. DC	nd of work done during most of work NOT use retired) Cary	ing	Engineering		
be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	niden Surname)		
should Ind Men	2	Claude M. Gay 19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Grace Address (Street and Number or Rur.	M. Lee	City or Town, State, Zip Code)		
and 2 s ealth au n 27 Is ner trau		Gretchen Basen / Daugh	nter 1207	Culvert Road T	owson, Ma	aryland 21286		
Pages 1 Tent of H Int: If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place of Disposit cemetery, crema. Hilltop Se		10000	Co. Location - City or Town, State Towson, Maryland		
permit. Departminitimports any inju		21. Signature of Funeral Service Licensee	/ /	Name and Address of Facility Tow		/land 21204 Inc. 1050 York Road		
o		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each	aused the death. Do not enter					
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ZHEIMERS (or as a consequence of):	D Emen	119	Onset and Death		
Examiner	-	Sequentially list conditions, b	(or as a consequence of):					
xecuted and Il-transit	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events c						
. 0 5 0	Ш	Due to	(or as a consequence of):					
eath certificate be e attending physician for use as the buria	/Medi	IF FEMALE: 23c. If yes, ou	tcome of pregnancy			23d. Date of delivery		
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the buri	Physician/Medical		nant at time of death 5 🔲 0	Ectopic pregnancy Other (specify)		Month Day Year		
es that the de igned by the be detached t	by Phy	Part II. Other significant conditions contributing to d	eath but not resulting in the unde	erlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?		
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The law cate has page 2 s	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
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g Physical this neral di	n: To	27. Manner of Death 28a. Date	Inpatient 2 ☐ ER/Outpatient of Injury ofth, Day, Year) 28b. Time of Injury	3 L DOA 4 A Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Specify) injury occurred		
Attending Physician: r death. ector: After this certific by the funeral director, I	icatio	2 Accident investigation		M 1 □Yes 2 □No	28f Location (Street	not and Number or Pumi Poute Number		
ital or At its after or ral Direc	Certification:	determined 200. Place	e of Injury - At home, farm, stree ing, etc. (Specify)	s, identity, office	City or Town,	et and Number or Rural Route Number, State)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: On the b		death occurred at the time, date and place, and due to the cause(s) and manner as stat /or investigation, in my opinion, death occurred at the time, date and place, and due to the				
To th	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)		

State

Registrar

BaltimorE MARY LAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AV DON W. D. 590 | North (

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 2 2009

APR 2 8 2009

State Registrar

29b. Signature and title of certifier

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31. Date filed (Month, Day, Year) APR 2 8 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

29c. License number

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29d. Date signed (Month, Day, Year)

26,2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Worrell ton 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Northwest Hospital Center 8. Date of Birth (Month, Day, May 27, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year)} 1925 **Funeral** Months Days Hours Min 224-24-7295 **X**□ M 2□ F VĂ 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm indicate in the instance of the standard in the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instance of the instan 10d. Inside City Limits 10c. City, Town or Location 10a. State 1XYes 2□No MD Director Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4800 Seton Drive 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: þ WWII 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory/Production Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Worrell unk P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 N. Charles Street, Baltimore, MD 21201 Mrs. Klecan, Social Worker Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/23/2009 Crownsville, MD MSVC-Crownsville 4 ☐ Donation 5 ☐ Other (Specify) Thomas J. Skarda Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 2829 Hudson Street, Baltimore, MD 21224 noman 23a. Part 1. Enter the disease, or complications that cause 1 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Stage Alzheimor **Physician** End disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Our to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown icate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Transitional Coll Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SONS I ESPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 15th 2008 144593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2935 Smith Avenue Baltimore MD 21209 31. Date filed (Month Registrar's Signatur State

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death P^{M} **Physician** April 23, 2009 3:47 Violet Rose Wible /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | MAR 3 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 84 220-12-8792 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a INvalout Evaniner must be routified at 1 Yes 2 No Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 1703 Rock Haven Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Wible, V10/ct Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Smith Lottie William Ruby Henrey ဥ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Rock Haven Avenue, Catonsville, MD 21228 Janice Arnold - daughter If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or c 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 04/28/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee H. Williams MacNabb Funeral Home, P.A. 21228 301 Frederick Road, Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 DAYS Cholicyshtis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 st autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 🖳 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours at er death within 24 hours at er death

To the Funeral Director

completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4/24/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

STREET.

Towson, MD

16931

N. CHARLES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** UIIIIAMS 40R11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Future Care-Lochern (nee Villa St. Michael) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Days Hours Min **Funeral** Months 1 □ M 2 □ F No.Carolina Dec 21, 1924 84 Director 238-20-3371 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at MYS 2∏No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21215 4300 Penhurst Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) MIlliams (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Social Security Administration Elementary/Secondary (0-12) Federal Government Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Lindsay George Lindsay ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4300 Penhurst Avenue Baltimore, Maryland 21215 Sherry Barber Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, Md. 04/22/09 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end-Stage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ∏Unknown 2 No 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3FT DOA 1 Yes 2 | No 1 🔲 Inpatient Certification: To this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 🗌 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) APR 28 2009

.s. Rajapaksemo

29b. Signature and title, of certifier

25 Mainst, suite 200, Reisterstown, 32. Registrar's Sinature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0057465

29d. Date signed (Month, Day, Year)

MD 21136

4/20/09,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 2009 8:00 A Lawrence н. Will /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F 80 Feb 11, 1929 Maryland Director 519-24-6446 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director Maryland | Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 Funeral 300 International Circle, apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify Specify. ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Municipal College (1-4or 5+) Elementary/Secondary (0-12) Engineering Civil Engineer 12 04 is 1 and 2 should be filed with Halth and Mental Hygier tem 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Will Dorothy ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cockeysville, 21030 Department of Health ar Important; if item 27 Is any injury or other trauonce. 300 International Circle, apt. Adele F. Will/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/24/09 Glen Burnie, Maryland 5 ☐ Other (Specify) Atlantic Crematory 4 □ Donation 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, Maryland 21093 une al Service Lice se 4 Bryan 23a. Part1. En'r the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart fullure. List only one cause on each line. Immediate lause (Fired disease or condition resulting in de 11h) DU/mmany Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last the attending physician and the for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown avering page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performac 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 DNo funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PLG 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation М 1 □Yes 2 □ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Will. Lawrence

4 - Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO 32. Registrar's §

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

G701 N Charles St

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day heelev Year **Physician** MO 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death Acility Name (If not institution, give street and number, Examiner WASh Burnie med Ien 50 10 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1**X** M 2□ F 217-50-8818 61 April Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Anne Arundel Co. Glen Burnie within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 708 Wimmer Road 21061 United States "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 68-70 Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Construction 12 yrs. permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schindler Margaret M. Norman L. Wheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, MD 21061 Mrs. Vickie L. Wheeler / Wife 708 Wimmer Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/28/2009 4 □ Donation 5 □ Other (Specify) Crownsville, Maryland MD Veterans Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 2nd Ave_SW, Glen Burnie, MD 21061 Services PA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclero 15805°C **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trans and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an ate has bage 2 s autopsy this certificate 1□ Yes 2 No funeral director. 25. Was case referred to medical exeminer? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) exeminer 1 Ves 2 ☐ R/Outpatient 3 ☐ DOA 2∏ No 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number)epurty 0605 address of person who completed cause of death (Item 23a) (Type, Print) America 2103 JONES, MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

PR 28 2009 Senera B. Jak

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Month Physician April 27, 8:00 Louise Wright Watson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Brighton Gardens 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 7,1929 Yrs Illinois 353-26-8040 Sept. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Evanture rust be notified at 1√XYes 2 □ No Directo Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 U.S.A. 6451 N. Charles Street, #106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Mental once. 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: <u>ک</u> 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gwendolyn Joseph Wright Morgan ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Tunbridge Road Baltimore, Maryland 21212 Edward M. Watson, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. May 4, 2009 Towson Maryland Signature of Funeral Service 22. Name and Address of Facility Licensee Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREASI CANCER 15 Years. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the neight of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending s after dea... investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 27, 2009 050760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK Rd. STE 307. 1407 LUTHGRUIK, - HARles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 28 ZUUS Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar C	ertificate of Death	Re	g. No. 2009	13551
	Physici		1. Decedent's Name (First, Middle, Last) JACK R. WEBER, SR.		2. Date of Death Month APRIL	25, 2009	3. Time of Death 5:38 A. ^M
1	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
- TF R	Funeral		GILCHRIST CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda for the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of the security Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of	Months Days Hours Min.	8. Date of Birth (Month, Day, 3/16/19	BALTIN Year) 9. Birth Cou	Place (State or Foreign ntry)
	Director		214-26-6697 1XIM 2 1F 79 Yrs. Usual Residence of Decedent		3/16/19	930 MAF	RYLAND
	aryland show	<u>_</u>	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1 □ Yes 2 ☑ No
	the M 28a-f	Director	MD BALTIMORE TOWN 10e. Street and Number	ISON 10f. Zip Code	10	g. Citizen of What Cou	
	th with	a Di	28 ALLEGHENY AVENUE	21204		USA	
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be motified at	by Funeral	1 ☐ Never Married 2 ☐ X Married 1 ☐ X es 2 ☐ No If Yes, Give	 Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify: 	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify:	etc.
0	2 hours atural'	ted b		cedent's Usual Occupation	. 1	6b. Kind of Business/Ir	/HITE ndustry
21215-0036	be filed within 72 ho ital Hygiene. d other than "natu event, tre Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work DO NOT use retired)			
	filed w Hygie other t		12TH GRADE PF 17. Father's Name (First, Middle, Last)	RINTER 18. Mother's Nam	ne (First, Middle, M	PRINTING aiden Surname)	
/lan		To Be	JOHN R. WEBER	HILDA	NEWCOMB		
Maryland	d 2 should th and Mer 7 Is marke traumatic	v i	Y	ailing Address (Street and Number or Ru			p Code)
ē,	Heal Heal em 2	1	20a. Method of Disposition 20b. Place of Dis	sposition (Name of	Date 2	21286 0c. Location - City or T	own, State
E O	9 = 5		1 LABurial 2 Li Cremation 3 Li Removal from State	rematory or other place) DD CEMETERY 4/3	0/2009 I	BALTIMORE,	MD
Baltimore,	permit. Pag Department Important: I any Injury c once.		21. Signature of Funeral Service Licensee MO1139	22. Name and Address of Facility TH 8521 LOCH RAVEN BL		N FUNERAL H	HOME, P.A.
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	511 010 0			week
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	scuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause Fit of the wind of the cause (Disease or injury that initiated events c.				
,60,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
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O. Box	ath cer attendir for use	Physician/N		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
J.	that the de ned by the a detached to	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	iw requires that s been signed b should be deta	ted b	Covoning Artery dise	450	1 ☐ Yes	s 2 No 3 Pro	bably 4 Unknown
Hecords,	e 2 s	Completed	Atrial fibrillation		24a. Was an autopsy perform 1 □ Yes 2	prior to co	opsy findings available ompletion of cause of 2 □ No
Vita	iclan: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Other:	th (Check only one)	6/
ō	Attending Physiclan: r death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	e of 28c. Injury at	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	ivit of pece
ion	ending sath. or: Afte he fun	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injur 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	e Hospital or Attendi 124 hours after death. e Funeral Director; A letely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town,		
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, drawing the desired form of the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the ca irred at the time, da	tuse(s) and manner as te and place, and due	stated. to the cause(s)
h	To the I within 2 To the I complet	M	29b. Signature and title of certifier And hung for the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	29c. License number	29	d. Date signed (Month	Day, Year) 7
			30. Name and address of person who completed cause of aeath (Item 23a) (Typ.	A. Charles S	i Boi	Ho me	21204
0	Sta		31. Date filed (Month, Day, Year) ADD 9 8 2009	arke			

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ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	13552
Certificate of Death Reg. No	

	Registrar			001	rtificate c	1 000	<i></i>				eg. No.			
Physician/ Medical Examine	1. Decedent's Na	me (First, Middle C. Wint				_				Date of Dea Month April 1, 20	Day 009	Year		3. Time of Death 1031 hrs
		(if not institution anklin Street	n, give street and nu #2	umber)		_	/, Town, or L gerstown	ocation of	Death			County of Vashing		
Funeral Director	5. Social Security		6. Sex	7. Age (In yrs. la		birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/D Months Days Hours Min. 08/29/194					Foreign			
	Usual Residence	of Decedent												10d. Inside City Limits
nd show any ncc.	10a. State MD	Washin	ngton	1	Town or Loca agerst									1 Yes 2X No
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and N					10f. Zip Code					10g. Citizen of What Country?			
with the ns 23a c	221 W. 11. Marital Status	Franklii unknown		cedent Ever in U.		as Dece	21740 edent of Hisp						- Americ	an Indian, Black,
			rried Armed F 1 Yes orced If Yes, Give Yes	2 No			ecify Cuban, l		Риепо кі	ican, etc.)		White,		te
hours aft "natural" Examine	15. Decedent's	Education (Spec	ify only highest gra		16a. Decede		ıal Occupatio vorking life. [16b. k	Kind of Bus	iness/Ir	ndustry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	unknow	'n	unknow	· ·		un	known					unkn	own	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medisa FO BE COMPIL			Last)				18		Name (F nown	First, Middle,	Maiden	Surname)		
MD 21215-00; d 2 should be filed with th and Mental Hygiene n 27 is marked other ti numatic event, the Mee To Be Com	19a. Informant's I		nip(Type,Print) er office	5			ess (Street							Zip Code)
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	20a. Method of D			20b. I	Place of Dispo	sition (N	lame of ceme			Date				Town, State
Baltimore, permit. Pages 1 an Department of He Important: If ite	4 Donation	5 X Other Spe	_{ecify:} insta	ite	22	Name a	nd Address o	of Facility		-			1	
	11/11	2///	e, Direct	ke _			nd Address of st Ba							21201 Approximate Interval
Physician /Medical		only one cause of	complications that con each line. a. Hepatocell			the mod	ie or dying, s	uch as car	rdiac or n	espiratory ar	rest, snc	ock, or nea		Between Onset and Death
xaminer	or condition resu	Iting in death)		a consequence o										
niner	Sequentially list of if any, leading to cause. Enter Un	immediate derlying Cause	Due to (or as a	a consequence o	rf):									
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8760, itificate be executed ing physician and as the burial - transit	UNPENDE	D	AMENDED									GE 15		
Ox 68760, sath certificate be attending physic or use as the bur sician/Med			e 1 Live I	outcome of preg birth nant at time of de	2 F	etal dea		Ectopic	pregnand	су	230	d. Date of d Month		ay Year
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i, P.O. Box 6 res that the death cer signed by the attendi t be detached for use d by Physicia	Complica		ons contributing tenic alcohol ab		•	underly	ing cause giv	ven in Part		1 Ye				he cause of death? ably 4 🗹 Unknown
Vital Records, P.C ysician: The law requires that his certificate has been signed director, page 2 should be dere on Be Completed by		_								24a. Was	psy ormed?	pr		opsy findings available ompletion of cause of
I Rec n: The l or, page		erred to medical					26.Place o	of Death (C	Check on	1 Yes	2 N		✓ Ye:	s 2 No
Vital ysician ysician his cert directo	examiner? 1 ✓ Yes	2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3	DOA C	Other 4	Nursing	Home 5	Reside	ence 6 🗸	Other:	Scene
in of Viding Physics in After this efuneral different To				e of Injury h, Day,Year)	28b. Time of	Injury	28c. Injury	at Work?		8d. Describe	how inju	ury occurre	ed	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi edical Certification: To Be Completed by Physician/Medical Es	2 Accident 3 Suicide	6 Could	tigation	ce of Injury - At h	ome, farm, str	eet, fact	ory, office bu	ilding, etc.	. 2	8f. Location or Town,		and Numbe	r or Rur	al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		Certifying Ph	ysician: To the be	st of my knowled	lge, death occ	urred at	the time, date	e and plac	e, and du	ue to the cau	se(s) an	nd manner	as state	d. s cause(s)
To the Ho within 24 To the Fu completel	29b. Signature ar		and manner	stated.			29c. License	number						th, Day, Year)
	30 Name and an	idress of person	who completed cau	oh r	1 23a)		O.C.N	I.E.			Apri	il 2, 200	9	
	Patricia Ai	ronica-Pollak	MD. Assist	ant Medical	Examiner		Penn Str	eet, Bal	timore,	MD 2120)1			
State Registra	31. Date filed (Mo	APR 28 2009 Linux P. Registrar's Signature												

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** April 21, 2009 7:50AM M Barry White /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 12 M 2 □ F **Funeral** New York January 24,1922 147-16-3914 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 3a or 28a-f show t be notified at 10a. State 10b. County 1 ☐Yes 2 No Director Charlotte Hall MD ST. Marys 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 29449 Charlotte Hall Road 20622 "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 1942—1945 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 **≙** 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation marked other than "natu matic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unknown 12 Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be 2 should be Doris White Maxwell Goldsmith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an important; if them 27 is many injury or other 3021 Fallsatff Road #102, Baltimore, MD Cyrile White Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 West Baltimore Street, Baltimore, MD 21201 20a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) House Myocaxchial infonction **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): Box 68760. physician be Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. ed by the a detached f 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? Aspiration Preumonia 24a. Was an autopsy 1 ☐ Yes 2□ No 2 No Hypotension 1☐ Yes 25. Was case referred to medical examiner? Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🖪 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide ō Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D. 50653 surana. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURANA Deale church ton Rood Deale 2. Registrar's Sign ture 31. Date filed (Month, Day, Year) State APR 28 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan	•	rtificate of		, ,	eg. No. 2 0 0 1	0 12551
	Physici		1. Decedent's Name (First, Middle, Last Shirley Eliz	^{st)} Zabeth Zari	fos			2. Date of Death	23 2009	3. Time of Death 4
~~~	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			or Location of Death		4c. County of Dea	ath
-	Funeral		19 Kate Wagner 5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	Westmi  If Under 1 Year  Months Days	If Under 24 Hrs.	8. Date of Birth	Carrol 9. Bi	Thplace (State or Foreign ountry)
F	Director		187-24-2319 Usual Residence of Decedent	□м 2 <b>X</b> Эг 77	Yrs.	Wortins Days	Tiours Willi.	MAY 3 1	.931 Pen	nsylvania
	uryland show	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	the Ma 28a-f	recto	MD Carrol1  10e, Street and Number	_ We	es cm r	10f. Zip Code		110	0g. Citizen of What C	1 ☐ Yes 2 🔼 No
	th with 23a or	al Di	19 Kate Wagner	Court		2115	57		USA	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at actified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4X Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 □Yes 2★No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 □Yes 2X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	72 ho "natur	Completed by	15. Decedent's Ed (Specify only highest gra	ducation de co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of work ed)	king	16b. Kind of Business	/Industry
2121	within giene. r than	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retire stered			Health C	are
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N		1
ryla	hould nd Men marke matic	၀	Leroy Allen  19a. Informant's Name/Relationship (*)	Nease	10h Mailir	nn Address (Stree	Margare		ah Kna City or Town, State,	
, Ma	and 2 sealth ar 27 is er trau		R. Thaumas Bok	**	T		er Court,			2115 <b>7</b>
Baltimore, Maryland	Pages 1 ament of He ant; If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hernoval from State	lace of Dispo emetery, cren ro Cre	sition (Name of natory or other pla <b>matory</b> ,	Inc. 04/2	1	20c. Location - City or Baltimore	
Balt	permit, Depart Import any inj once,		21. Signature of Funeral Service Incention	ff. Williams	2	remation 99 Frede	Society crick Road	of Maryl , Baltim	and, Inc. ore, MD 2	21228
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, P.O. Box 68760,	that the death ce ed by the attendii detached for use	/ Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  Part II. Other significant conditions or	23c. If yes, outcome of pregna 1  Live birth 2 Fetal 4  Pregnant at time of d 9  Unknown	cy ven in Part I.	23e. Did tob	23d. Date of de Month	olivery Day Year of the cause of death?		
rds	w requires been sign should be	ed by						1 1026	s 2 □ No 3 □ F	robably 4 🗌 Unknown
Vital Records,	hysician: The law re his certificate has be I director, page 2 sho	Be Completed	25. Was case referred to medical				26. Place of Deat	24a. Was an autops) perform 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of s 2 □No
of <	Physic this ce al dire	P	examiner 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury		1 3 DOA			nce 6 □ Other (Spe	ecify)
Division of		Certification:	Manner of Death    Matural   5   Pending investigation	(Month, Day, Year)	28b. Time of Injury me, farm, stre		rk? ]Yes 2 □No	28d. Describe hor 28f. Location (Str City or Town,	reet and Number or R	ural Route Number,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death tion and/or in	n occurred at the t vestigation, in my	time, date and place, opinion, death occur	, and due to the carred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	0 2 1 10	6	29c. Licen	se number		d. Date signed (Mon	
		-	30. Name and address of person who o	completed cause of death (Item	23a) (Type !	Print)	06450	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	24 April 2	2009
			Dr. Robert L. Ric	e, MD, 555 Sou	th Cen	,	et, Westm	inster,	MD 21157	
	Sta Registra		31. Date filed (Month, Day, Year)  APR 2 8 200	9 Personal Signat	ure par	Ked	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 3555 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 9:00 pM 2009 April 09 Robert Oliver 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville Shady Grove Adventist Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Hours Days Months 1 🗷 M 2 🗆 F Yrs Illinois February 13, 1922 87 340-18-4529 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County

10f Zin Code

1 ☐ Yes 2 🗷 No

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronic Engineer

Rockville

20853

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

34A Cresencio Lane, Santa Fe, New Mexico

1 ☐ Yes 2 X No

Caucasian

10g. Citizen of What Country?

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Emma Reitz

16b. Kind of Business/Industry

20c. Location - City or Town, State

U.S.A.

14. Race - American Indian, Black, White, etc.

National Security Agency

3 Probably 4 ₩ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 ☐ No

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ite Medical Examiner must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 sirous Control Department of Health and Mental Hygiene. 1 - For State Registrar

10a. State

Maryland

10e. Street and Number

Montgomery

15. Decedent's Education (Specify only highest grade completed)

KASID

TAN

31. Date filed (Month, Day, Year)

Herman Carl Alde

12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No

WWII

1 ▼Yes 2 ☐ If Yes, Give Year or Dates:

College (1-4or 5+)

5215 Drake Terrace

1 ☐ Never Married 2 ☐ Married

3 X Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Douglas Alde - Son

Director

Funeral

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Completed

Be

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**Physician** 

**Examiner** 

**Funeral** 

Director

/Medical

Phy: /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Domaval from State	20b. Place of Disposition cemetery, cremate	on (Name of ory or other place)	Date	20c. Location -	City or Town, State
- 1	4 □ Donation 5 □ Other (Specif		Fort Lincoln	Crematory	04/20/2009	Brentwood	i, Maryland _
	21. Signature of Funeral Service Lice	nsee	Hin	ame and Address of Fa es-Rinaldi Fu OO New Hampsh	meral Home, Inc	c. lver Spring	, Maryland 2090
	23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not enter t	he mode of dying, sucl	h as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Deat
	Immediate Cause (Final disease or condition	a. Pancreat	ic Cancer				
	resulting in death)	Due to (or as a	consequence of):				
	Sequentially list conditions	b. Arrhythm	ia				
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Uncarping Cause (Disease or injury	Due to (or as a	consequence of):				
Examin	Cause (Disease or injury that initiated events	c. Dysphagi	ia				
Ĭ	resulting in death) Last	Due to (or as a	consequence of):				
		d.					
Ē							110
Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐ E	ctopic pregnancy ther (specify)		23d. Dai	e of delivery nth Day Year
Completed by P	Part II. Other significant conditions	contributing to death bu	t not resulting in the unde	rlying cause given in P	1 E	Yes 2 No	ribute to the cause of death  3 □ Probably 4 ☑ Unkr  Were autopsy findings availation of causdeath?
3						2 🖾 No	1 □Yes 2 □No
Be	25. Was case referred to medical examiner?	1111-1-			Place of Death (Check only	v one)	
0	1 Yes 2 ⊠ No		nt 2 ER/Outpatient		Nursing Home 5 ☐ Re		
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		y 28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes		e how injury occurr	ed
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, street . <i>(Specify)</i>	, factory, office	28f. Location City or 7	(Street and Numb own, State)	er or Rural Route Number,
Medical (	29a. Certifier 1 Certifying P  (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or inves	ccurred at the time, da stigation, in my opinion	te and place, and due to to , death occurred at the tim	he cause(s) and m e, date and place,	anner as stated. and due to the cause(s)
Me	29b. Signature and title of certifier			29c. License num	ber	29d. Date signe	d (Month, Day, Year)
	I A May	1	D				

State Registrar

604 S. Frederick St., Suite 409, Gaithersburg, Maryland 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar_AMEND#20loperFH4/14/09,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Year Month Salvatore C. Barile 8 A 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Formation Months | Days | Hours | Min. | April 26,1918 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ★ M 2 🗆 F 098-01-9514 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Berwyn Heights 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6117 Seminole Street 20740 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give T 7 7 T T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify White Specify: Year or Dates: WWT.T 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Offset Photographer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Salvatore Barile Anna Mantione 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 Jacobs Drive Greenbelt, Maryland 20770 Salvatore P. Barile -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonardadre Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 erral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic cardianyapat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery in the past 12 moo 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 NO 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Natural

**Physician** /Medical Examiner requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

2

Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, it e Medical Expriner must be notified at

72 hours after

d 2 should be filed with and Mental Hygier 7 is marked other the

Health a

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

Saltimore, Maryland 21215-0036

burial-tran and tending physician are use as the burialattending p the a signed by the peen

Box 68760.

P.O.1

Division of Vital Records,

Examiner Physician/Medical Ş Completed cate has by page 2 s certificate director. Be ပ္ After the funeral Certification: death. neral Director: A after

To the Hospital or Attending Physician; within 24 hours a ZO + (

Medical

State Registrar

IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? 27. Manner of Death 1 □Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

H0065

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arkwo 200

Monica Salan 31. Date filed (Month, Day, Year)

		Please	Type or Print in State of Maryla				-	_	
		1 - For State Registrar	Otate of Maryle	•	rificate of D			eg. No() () () ()	13557
Physic	ion	1. Decedent's Name (First, Middle, La	st)	4			2. Date of Death	Day Year	3. Time of Death
/Med		tatricia	Anne	Bake		10.00	04	11 2000	
Exam	ner	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or I		D	4c. County of Dea	
Funera		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year   Months Days	1./	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign country)
Directo		578-52-5259 Usual Residence of Decedent	□ M 2 <b>Y</b> F	( ) Yre			09 01		ennsylvania
yland yland		10a. State 10b. County	10c. (	City, Town or Loca	ation				10d. Inside City Limits
e Mar Ba-f sh	Director	Maryland Garrett	t F	rostburg					1 ☐ Yes 2 No
'72 hours after death with the Marylan "natural", or items 23a or 28a-f show		10e. Street and Number 62 Wilh	elm Lane		10f. Zip Code			g. Citizen of What C	country?
ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. W	as Decedent of His	spanic Origin? (Spec	cify Yes or No-	U.S.A.	nerican Indian,
after o		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		Yes, specify Cubar □Yes 2 <b>ĭX</b> No	, Mexican, Puerto R Specify:	lican, etc.)	Black, Whi	ite, etc.
ural",	d by	3 Widowed 4 Divorced	Year or Dates:		_				hite
in 72 l	Completed	15. Decedent's Et	ade completed)	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)	iring most of working		6b. Kind of Business	s/industry
d with giene er thau	No.	Elementary/Secondary (0-12)	College (1-4or 5+)	admin.	Assistant			regulatory co	mmission
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. It has 23a or 28a-f show other traumatic event, the Western Examination of the real market of the Western Examination of the real market of the Western Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination of the Medical Examination	Be	17. Father's Name (First, Middle, Last	)			18. Mother's Name		laiden Surname)	
hould nd Mer marke marke	ြင	Chester F. Moore  19a. Informant's Name/Relationship (	Type Print)	19h Mailing	Address (Street a	Helen B . O		City or Town, State.	Zin Code)
12 # d		Debbie Huffer	daughter	"	ecesaris Drive		,	Maryland	' '
es 1 ar of Heg fitem		20a. Method of Disposition 1 ☐ Burial 2 BCremation 3 ☐	20b	. Place of Disposi cemetery, crema	tion (Name of atory or other place	) Da	ite 2	20c. Location - City o	r Town, State
t. Pages tment of tant: If its		4 ☐ Donation 5 ☐ Other (Special	(y)		d Crematory		i 12, 2009	Cumberland	Maryland
permit. Pages 1 D. partment of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licer	N) uni		Name and Address	•	rost Ave 1	Frostburg, MI	21532
		23a. Parl 1. Enter the disease, or com	plications that caused the de						Approximate Interval Between
Physician		Inmediate Cause (Final disease or condition	Ple uso	00.12					Onset and Death
/Medica		resulting in death)	Due to (or as a cons	quence of):					107
Examine	٠,	Sequentially list conditions,	b. LLM9 C. Due to (or la a consi	awac ex.					541
executed n and ial-transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
	ш	resulting in death) Last	Due to (or as a cons	equence of):	V				1
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	sician/Medical	•	d. Liver	Cance	V '				8 4
certifis nding p	/Me	IF FEMALE;	23c. If yes, outcome of preg	ınancy				23d. Date of de	alivery
death e atter	iciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy Other (specify)			Month	Day Year
that the dended by the a	Phys	9 🗌 Unknown	9 Unknown				00. 0:14-5		
ires th signed	<b>₽</b>	Part II. Other significant conditions	contributing to death but not r	esulting in the und	derlying cause giver	n in Part I.	1 ☐ Ye		to the cause of death?  Probably 4 Unknown
w requir	eted						24a. Was an		autopsy findings available
he lav te has	Completed						autopsy perform	prior to	completion of cause of
Physician: The la r this certificate har ral director, page 2	Be C	25. Was case referred to medical				26. Place of Death			s 2 No
hysic this ce	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient		4 La Ivuising non		nce 6 Other (Sp	ecify)
	ion:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	at ? es 2 □ No	8d. Describe ho	w injury occurred	
ding P			"				8f. Location (Str	eet and Number or F	Rural Route Number
Attending P r death.	ficat	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At	home, farm, stree	et, lactory, office	-			
tal or Attending P rs after death. al Director: After i	Certification:	3 Suicide 6 Could not b determined	building, etc. (Spe	city)			City or Town,	•	
e Hospital or Attending P 24 hours after death. Funeral Director: After letely filled in by the funera	_	3   Suicide 6   Could not be determined	28e. Place of Injury - At	nowledge, death	occurred at the tim	e, date and place, a	City or Town,	ause(s) and manner	as stated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certificat	3   Suicide 4   Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (Spenty learning)  hysician: To the best of my learning: On the basis of exam	nowledge, death	occurred at the tim	e, date and place, a inion, death occurre	City or Town, and due to the ca d at the time, da	ause(s) and manner	as stated. ue to the cause(s)

State Registrar 31. Date filed (Month, D

DHMH 17 Rev 1/2001

MAS

ent Ave Suit 204 Camberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		4	For State	Sta	te of Mar		partment of F e <i>rtificate of I</i>		nd Mental H		0000	10550
			Registrar  1. Decedent's Name (First,	Middle Last)				Dealli	2. Date of I	Reg. No	2009	3. Time of Death
Р	hysicia	_							Month Apri	1 7		1:55 AM
**	/Medica Examine		ELEANOR S.  4a. Facility Name (If not ins		and number)	<u>-</u>	4b. City, Town, or	r Location of			. County of Death	
	.xamme	er .	Genesis He	althCare	- Th	e Pines	Ea	ston			Talbo	ot
Fu	ıneral		5. Social Security Number	6. Sex	7. Age (	(In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Month.	Birth Day, Year	9. Birth	nplace (State or Foreign untry)
Dir	rector		213-24-4580		82	Yrs.			JAN 1	, 192	.7	MD
and	M.	}	Usual Residence of Decedence  10a. State 10b. C		1	Oc. City, Town or	_ocation					10d. Inside City Limits
Maryl	f sho	ğ	MD	TALBOT		EASTON						XXYes 2□No
the	r 28a	Director	10e. Street and Number	1,000		2020-1-21	10f. Zip Code			10g. C	itizen of What Co	untry?
h with	23a o	a D	610 DUTCHMA	NS LANE			1	21601			USA	
deat	swe	Funeral	11. Marital Status	12. Wa	s Decedent Evened Forces?	er in U.S.	3. Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White	rican Indian, o, etc.
36 after	or its		1 Never Married	Married 1 [	Yes 2		1 □ Yes 2√√No	Specify:				WHITE
000 hours	ural"	od by	3 Widowed 4 Di	vorced Ye	ar or Dates:		cedent's Usual Occup	nation		16b k	(ind of Business/l	
<b>15</b> n 72	ledic	Set	(Specify only	cedent's Education highest grade comp		(Gi	ve kind of work done  . DO NOT use retire	during most ( d)	of working			,
212 212 I with	than	Completed	Elementary/Secondary (	J-12) Co	llege (1-4or 5+)		HOMEMAKER			OV	N HOME	
d illed	othe vent,	Be C	17. Father's Name (First, A	fiddle, Last)				18. Mother	's Name (First, Mide	dle, Maidei	n Surname)	
Butler aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	arked atic e	2	TILGHMAN W.	SCOTT				MA	RY F. CHE	EZUM		
Bu lary	raum raum		19a. Informant's Name/Re		int)	1	illing Address (Street 77 MANADI)				or Town, State, 2 21673	Zip Code)
e, l e, l and lealth	am 27 ther t		BRUCE E. BUT						Date		ocation - City or	Town, State
Eleanor Butler Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	or o'		Burial 2 Crem	ation 3 Remova			position (Name of rematory or other pla	i			•	
lei	ortant injury	- 1	4 ☐ Donation 5 ☐ O  21. Signature of Funeral S		_		SH CEMETE		4-13-2009		RAPPE, M	HOME, P.A.
Dep Perm	any and	. 9	JOHN	R M	ERCE	RON	200 S. HA	RRISON	ST. EAST	ON, 1	токвада Ф 21601	
			23a. Part 1. Enter the dise shock, or heart failur	ase, or complication e. List only one cau	s that caused th se on each ling.					y arrest,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition	_ a	Ada	ult tai	Ture to t	thrive				month
	edical miner		resulting in death)		Due to as a	consequence of):	Ture to to	1.				110008
		<u>-</u>	Sequentially list conditions	b. —	Due to (or s a	consequence of):	alemen	ne				years
uted	tusit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	4								
D,	an and ial-tra		resulting in death) Last	С	Due to (or as a	consequence of):			-			
<b>68760,</b> Ificate be executed	physician and s the burial-transit	edical		d								
68 artifica	as th		IF FEMALE:	-			-			1		
Box eath cer	ttendi	Physician/M	23b. Was decedent pregn in the past 12 months	ant 1	yes, outcome of Live birth 2	Fetal death	3 🗌 Ectopic pregnan			- 1	23d. Date of de Month	livery Day Year
O. H	the a	/slci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 1	□ Pregnant at t □ Unknown	ime of death	5 Other (specify)			_		
P.O.	ed by detac		Part II. Other significant of	onditions contributi	ing to death but	not resulting in the	underlying cause gi	ven in Part i.	23e. D	id tobacco	use contribute to	the cause of death?
Division of Vital Records, nor Attending Physician: The law requires the after death.	ld be	d by	1	uperteusir	⁹ n				1	□Yes	2 □ No 3 □ P	robably 4 Unknown
CO w	shou	Completed		Tumtlun	milite					Vas an	24b. Were at	utopsy findings available completion of cause of
<b>B</b> Fe is	age 2	m o		/					—— a p 1 □ Ye	utopsy erformed? es 2 10 10	death?	_/
ital	rtifica tor, p	Be C	25. Was case referred to	nedical				26. Place	of Death (Check or			
f V	nis ce I direc		examiner? 1 ☐ Yes 2 ☐ No	Hospita	^{al:} 1 □ Inpatien	it 2 ☐ ER/Outpa	tient 3 LI DOA		rsing Home 5 F			ecify)
r o a	After t	Ë	27. Manner of Death Natural 5	Pending	<ol> <li>Date of Injury (Month, Day,</li> </ol>	/ 28b. Time Year) lnjur	y Wo			ibe how inj	ury occurred	
SiO Itendi	tor: /	cati	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	- Diago of Injur	At home form	M 1 5 street, factory, office	]Yes 2□N		n /Street	and Number or R	ural Route Number,
Oivi or At	Direc in by	Certification: To	4 Homicide	determined	building, etc.	(Specify)	street, factory, office			Town, Sta		.,
Spital	To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 C	ertifying Physician	n: To the best of	f my knowledge, d	eath occurred at the rinvestigation, in my	time, date an	d place, and due to	the cause	(s) and manner a	as stated. e to the cause(s)
<b>the H</b> hin 24	the F	Medical	one)	a	nd manner state	ed.		nse number			Date signed (Mon	
To Viti	<b>2</b> 8	_	29b. Signature and title of	MAR	on This		7.	7759	33		4.7.1	79
			30. Name and address of	person who complet	tee cause of dea	ath (Item 23a) (Tvi	pe, Print)	1	)		, , ,	
· 6			MICHAEL (	ROWLEY	mo a	تنال ال	TCHMANS	MANE	LAS	TON,	1117 º	11601
pa	Sta Registr	- 1	31. Date filed (Month, Day	0 9 2009	32 Registrar	r's Signature	fall					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9011 **Physician** 13,2009 Carol Ann Bercaw /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 214-56-0957 61 Dec. 1.1947 Indiana Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show Alical Examiner must be notified at 1 XYes 2 No Funeral Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21740 33 E. Washington St. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry in and 2 should be filed within 72 hour Health and Mental Hygiene.

tem 27 Is marked other than "natur other traumatic event, the Modical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Private Home Care Elementary/Secondary (0-12) Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Isabelle Souza Brown Palfert C. Brown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 118 North Cleveland Ave. Hagerstown, MD 21740 Patrick Livesav-son permit. Pages 1 a Department of Her Important: If item any injury or othe once. 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Smithsburg Crematory 4-15-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CIRAHOSIS OF Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1L10PSOAS muscue Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed MRSA attending physician and for use as the burial-trar Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by ENCEPHALOPATIT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No DI ABETES MELLITUS 24a. Was an cate has I page 2 s autopsy perform PLEURAL this certificate 1 ☐ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) After thi funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

leral Director; A
filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EAST ANTIGTAM ST HAYELSTOWN MD AGYAKO-WIRODU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 15 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene, 3560 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John George Bauernschmidt 5:26 P M April 2009 /Medical la. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 216-50-4504 63 Director 2, Jan. 1946 Maryland Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel r than "natural", or items 23a or 28a-f ships Medical Everying must be notified Director Annapolis 1 ☐ Yes 2X No the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1099 Broadview Drive 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXXIII Yes. Give Specify. White Specify: Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "I other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event, the Missian other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Technician NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John N. Bauernschmidt Margaret Weaver ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Laita/friend 1099 Broadview Drive Annapolis, Maryland 21409 fitem 2. Baltimore, 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State ± 5 permit. Page Department of Important: If any injury or once. Baltimore Crematory 4/14/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home odd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if en, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of law requires that the death certificate be executed Proumouia and Medianistrifes and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş ongestive Heary 1 Yes 2 No 3 Probably ≯ Unknown Completed page 2 should peen semi c 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1- Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of pr 29c. License number 29d. Date signed (Month, Day, Year) 4337 De Molical Pray Amapolis, MD 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Judy Joseph-Herbert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Down B. park

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland State of Maryland Registrar		rtificate of		, ,	Jiene leg. No. 🤈 🗎 🗎 🔾	12561
r	Physici	an	1. Decedent's Name (First, Middle, Last)	1			Date of Dea     Month	Day Year	3. Timte of Death
	/Media	al	Rhoda Louise Brown Broad  4a. Facility Name (If not institution, give street and number)	ıy	4h City Town o	r Location of Death	April	5, 2009 4c. County of Deat	6:06 A. M
	Examir	ier 3	1927 Red Oak Drive		Adelph			Prince G	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day		hplace (State or Foreign untry)
Н	Director		266-78-8360 1 □ M 2 M F 71  Usual Residence of Decedent	Yrs.	Worten Days	Tiodio Tivili.	July 3	l, 1937 F1	orida
	iand ow			Town or Lo	cation				10d. Inside City Limits
	a-f shiffied a	tor	Maryland Prince Georges	Ade1p	hi				1 <b>X</b> 1Yes 2 ☐ No
	ith the or 28; e not	Director	10e. Street and Number		10f. Zip Code		1	log. Citizen of What Co	untry?
	s 23a	ral	1927 Red Oak Drive	1.0.	2078			United Sta	
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 【 Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Yes 2 【 No If Yes, Give Year or Dates:		was becedent of H If Yes, specify Cuba I Pes 2 <b>K</b> No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Amer Black, White Specify: <b>B1</b>	e, etc.
5-0	72 hc 'natur dical	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done	oation during most of worki	ing	16b. Kind of Business/	Industry
121	within iene. than " he Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade		OO NOT use retired uet Wait:			Quality In	n
92	e filed y al Hygie other vent, tt		17. Father's Name (First, Middle, Last)	Danq	uet wait	18. Mother's Name	(First, Middle, i	<u> </u>	11
lan	should be and Mental s marked o	To Be	Willie Horace Brown, Sr.			Alice	Louise	King	
Maryland			19a. Informant's Name/Relationship (Type. Print) (Husband)	19b. Mailin	ng Address (Street	and Number or Rura	al Route Number	r, City or Town, State, 2	(ip Code)
	1 and 2 Health em 27		Wardell Norman Broady, Sr.	1927	Red Oak	Drive; Ad		Maryland 20	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 23 Dullai 2   Clemation 3   Removal from State		sition (Name of natory or other plac		- II,	20c. Location - City or	
Ħ	permit. Pa Departmer Important: any injury		4 □ Donation 5 □ Other (Specify) Par		Memoria]			Rockville,	Maryland Morticians,
Ba	Depa Impo any is		Handelph B. Holl		True .				on,D.C.20011
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)  Advanced Bre	ast Ca	ancer				Onset and Death
	/Medical Examiner		Due to (or as a conseque	ence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Finter Underlying Cause (Disease or injury	ence of):					
	outed id ansit	Examiner	Cause (Disease or injury that initiated events						
ó,	ificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a conseque	ence of):					
68760,	ohysic the bu	edical	d						
			IF FEMALE: 23c. If yes, outcome pf pregnan	CV				7	
Вох	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months?	death 3	Ectopic pregnancy Other (specify)	У		23d. Date of deli Month	very Day Year
Ö	w requires that the de been signed by the should be detached	hysi	1 ☐ Yes 2 【 No 9 ☐ Unknown 9 ☐ Unknown						
S, D	ss that gned t	by P	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	equire en sig outd b	ted					1 🗆 Y	es 2 <b>X</b> No 3∏Pro	obably 4 Unknown
Records,	has be	Completed					24a. Was a	sy prior to d	topsy findings available completion of cause of
	± ege ±	Coo					perform 1 Yes	med? death? 2X No 1 ☐ Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be o	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ E	D/O 1	Oth	26. Place of Death	`		
0	g Phy er this	7: To	27. Manner of Death 28a. Date of Injury 2	28b. Time of	, SU DOA	4 LI Nursing Ho		ence 6 Other (Spec	cify)
ion	Attending r death. ector: After by the fune	atio	1X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 □ No			
Division or	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	:	28f. Location (St City or Town	treet and Number or Run, State)	ral Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in		On Continue A W. C. W. C. T. C	11		- 4			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	iedge, death on and/or inv	n occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		9d. Date signed (Month	
	01		· (- Voneylor, M.D.		D685			April 8 ,	2009
	(3)		30 Name and address of person who completed cause of death (Item 2	23a) (Type, I		Mercantil , Marylan		4	
~	Sta	te	31. Date filed (Mbnth) Day, Year)  APR 1 5 2009	ire	nargo	, naryrall	u 2011	<u> </u>	
-	Registr	ar	APR 15 2009 Beneg 1	4					

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Sheila Marie Barton 2009 County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death George Q1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 943 Days 1 □ M 2 🗶 F 65 579-58-3156 20 Washington, D.C. November Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1XYes 2 No District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 3600 Ely Place, S. E.; Apt. 224 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 □Yes 2 **X** No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S.Dept. of Housing Elementary/Secondary (0-12) College (1-4or 5+) & Urban Development Program Analyst 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert McKenzie Aretta S₁oan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey McKenzie Barton (Son) 3600 Ely Place, S.E.; Apt. 224; Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 2009 1 ■ Burial 2 □ Cremation 3 □ Removal from State April 11 Fort Lincoln Cemetery Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Limpse 22 Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherotic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes Z☐No 25. Was case referred to medical examine? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

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23a

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othk any injury or other traumatic event, OMCB.

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Funeral

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Hospital or Attending Physiclan: he lay requires that the death certificate be executed attending physician and for use as the burial-trar this funeral After t death. after death Director: the

Division of Vital Records, P.O. Box 68760.

filled in by

Examine Physician/Medical ģ Completed Be Certification: To

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Yes 2 No 27. Manner of Death 5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Registrar's Signature

State Registrar

within 24 hours a

To the Funeral C

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completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ATrell /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEVE GES Hospital Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 X M 2 □ F 578426654 Director Wash, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City. Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating that be notified at 1 ☐ Yes 2 No **Funeral Director** tin 6 Ton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Maintenance TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0015 arril oaker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type. Print) ,#204, Suitland, mD. SISter bara 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State aurel Mi). 7-11-09 MD. National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 420 HSTINE-21. Signature of Funeral Service Licensee 22. Name and Address of Facility m01178 W.DC. 2000Z Idenu tuneral 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiovascular 220921 /Medical Due to (or es a consequence of): Examiner Ripheral Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or all a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi oronar P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 Other (specify) 2 No signed by the 9 Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Hear 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate enal +ail 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 | Yes 2 | 1 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 8600 D31528 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Margaret Akpan 32. Registrar's Signature Landover, State

DHMH 17 Rev 1/2001

Registrar

	1 - For State Registrar				Cer	tificate	of Dea	ath		leg. No. 2 (	009	1356	
an al	Decedent's Name (First	st, Middle, Las	,	Robert	Bitne	r Sr.			2. Date of Dea	D	2008	3. Time of Death 12: 20 P.	
er	4a. Facility Name (If not in NMS Healt			mber)			wn, or Loca	tion of Death			ty of Death	ion	
	5. Social Security Numbe 188–05–7042	1	ex MM 2□F	7. Age (In yrs. Ia 93	ast birthday) Yrs.	If Under 1		nder 24 Hrs. urs Min.	8. Date of Birth Month, Day July 10	1915	9. Birthp	place (State or Fore ntry) na.	
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irec	10e. Street and Number				-	10f. Zip Co	ode	_		10g. Citizen of What Country?			
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by Funeral Director	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ □		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	ve No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Bla	ace - Americack, White,	etc.	
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ြ	19a. Informant's Name/P				19b. Mailin	a Address (S	Street and N		ral Route Numbe	r City or Town	n State Zin	Cadal	
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edical Examiner	23a. Part1. Enter the dis shock, or heart failt immediate Cause (Final disease or condition resulting in death)  Sequentially list condition days leading to mined cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns,	a. Let to b. Co	(or as a consequence of as a consequence of a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a	ence of):	feast_				601,		Approximate Interval Between Onset and Death	
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$\vdash \downarrow$	27. Manner of Death	Pending investigation	28a. Date (Mon		28b. Time of Injury		Injury at Work? 1 ☐ Yes		ome 5 ☐ Resid 28d. Describe h			ý)	
Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	□Could not be determined	28e. Place	of injury - At hor ing, etc. (Specify	- At home, farm, street, factory, office 28f. Local					Location (Street and Number or Rural Route Number, City or Town, State)			
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edical	29b. Signature and title of certifier									29d. Date signed (Month, Day, Year)			
Medical		of certifier				29c. L	icense num	ber	2	9d. Date sign	ed (Month,	Day, Year)	

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18 09 0905 04 Bane Merle Kenneth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland WMHS Braddock Campus If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 17⊈ M 2 □ F 76 10/25/1932 Maryland 217-28-2385 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show event, the Medical Examiner must be notified at 1 Tyes 2 No Director W Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a 26726 Funeral 332 Oak Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{DNo} \) 1953-If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ğ 3 Widowed 4 Divorced 1956 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event College (1-4or 5+) Elementary/Secondary (0-12) Public Schools 11 Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Bane Mary Ruth ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 332 Oak Drive, Keyser, WV 26726 Patricia A. Bane / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Cumberland Crematory 04/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Sign ture of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) isigned by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □/No 24a. Was an this certificate has all director, page 2 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and the of certifier 3+ of person who completed cause of death (Item 23a) (Type, Print) mpi-pelano now State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** Betty Frantz Bover April 22 2009 7:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days 1 □ M 2 ဩ F Director 213-24-7968 85 19, 1923 Greencastle, August Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov 1 ¥Yes 2 No Director Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ☐Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 📉 No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Important: if item 27 is marked other tha any injury or other traumatin events. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark F. Frantz, Sr. Margaret K. Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3823 Candlewood Court Boca Raton, FL Thomas F. Boyer 33487 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 23, 2009 Cumberland Valley Crem. Waynesboro, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ind. 50 S. Broad St. Waynesboro, PA 17268 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a chronic obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 √Yes 2 No 3 Probably 4 Unknown heart disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? not on dialysis Jas page 2 performed certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Faculity Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division of Vital Records, To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Contra Kuther-sands, so 747 Northern Avenue, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice of Washington County, Cynthia Kuttner-Sands MD Hagerstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature 28 2009

State Registrar 29b. Signature and title of certifier

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JK

29c. License number

D47451

29d. Date signed (Month, Day, Year)

Maryland 21742

April 22, 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Mary Leona Cortesini 1:00p M April 10, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 13207 Dumbarton Drive Rockville 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F June 15, 235-44-4501 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at MD Montgomery Rockville 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 13207 Dumbarton Drive USA 20853 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc 1 ∐Yes 2 120 If Yes, Give Year or Dates: 2 NO 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 ō 1 ∐Yes 2/XINo Specify White <u>ک</u> Specify: 3 Widowed 4 Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "na any injury or other traumatic event, the Media once. Union College (1-4or 5+) Elementary/Secondary (0-12) Clerk Typist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Witek John Sigh မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13207 Dumbarton Drive, Rockville, MD 20853 Henry Cortesini / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 15, 2009 Silver Spring 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Anellaura 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Carcinoma of Right Breast 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the criping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: nse If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ∐Yes 2**XX**No tached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ੬ icate has been si, , page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 K No 1 ☐ Yes 2 ☐ No is after deau...
ral Director: After this cer....
in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D02338 April 13, 2009 30. Name and address of person who completed cause of death (Item 234) (Type, Print) 3929 Ferrara Dr., Silver Spring, MD 20906 Richard P. Delaney 31. Date filed (Month, Day, Year) 32 Registrar's Signature. State APR 14 Registrar

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**Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exeminer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit MRS

	for State Registrar	State of Maryla		Certificate o			2009	13568				
	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Vass	3. Time of Death				
n ai	John	Walter		Cheney,	Jr.	Month	Day Year	8:21 A M				
er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	, or Location of Dea	April 1	4c. County of Death					
	475 Willowbrook	Road		Cumb	erland		Allega	ny				
	5. Social Security Number 6. Sex		s. last birth	day) If Under 1 Yea	r If Under 24 Hi		9. Birth	place (State or Foreign ntry)				
	219-56-7558 1-X	M 2□ F 57	Yr	s.	o Hodro Hviii	12/14/19		ryland				
	Usual Residence of Decedent	100.0	Nite Torres	u I sastis-				104 India City Limits				
_	10a. State 10b. County	106. 0	City, Town o	or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
sctc	MD Allega	ny		Cumberlar 10f. Zip Cod								
	10e. Street and Number	j. Citizen of What Cou	ntry?									
ra	475 Willowbrook		US	A								
nu	11. Walta States	2. Was Decedent Ever in Armed Forces?	U.S.	<ol><li>Was Decedent of If Yes, specify C</li></ol>	f Hispanic Origin? uban, Mexican, Pue	(Specify Ye's or No- erto Rican, etc.)	14. Race - Ameri Black, White,					
Ϋ́	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 M No If Yes, Give Year or Dates:		1 □Yes 2 ☑N	o Specify:		Specify:					
Completed by Funeral Director		14		hite								
Jete	15. Decedent's Educ (Specify only highest grade	orking	6b. Kind of Business/Ir	idustry								
щ	Elementary/Secondary (0-12)	* ,										
ပ္	17. Father's Name (First, Middle, Last)	4		Preside		ame <i>(Fir</i> st, <i>Middl</i> e, <i>Ma</i>	Lumber					
Be C		lter	Chene	y, Sr.	Rena	Ali	,	Friend				
ပ	19a. Informant's Name/Relationship (Typ			• /								
		,										
	Starr N. Cheney / N					Cumberlar Date 20	1d, MD 215 bc. Location - City or To					
	1 🕅 Burial 2 🗆 Cremation 3 🗆 Re	emoval from State	-	isposition (Name of crematory or other p				,				
	4 □ Donation 5 □ Other (Specify)		ınset	Memorial	Park: 04/	20/2009	Cumberlan	d, MD				
	21. Signature of Funeral Service License	man			Funeral I	1						
	Jule 7 Ch	Cerron		404 Deca		21502						
	23a. Part1. ENer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Onset and Death											
	disease or condition	Chronic Lym	phocy	tic Leuke	mia w/ Ri	ichter Tran	nsformation					
	Due to (or as a consequence of):											
<u>-</u>	Sequentially list conditions, b.	End Stage D	iffus	e Large E	Cell_Nor	n-Hodgkin I	ymphoma					
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of	:								
хап	Cause (Disease or injury that initiated events c. resulting in death) Last		acuence of									
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dic	d					_						
<b>₩</b>	IF FEMALE:	3c. If yes, outcome of preg	nancy				22d Data of dalli					
clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	tal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of delive	Day Year				
ysi	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	rucaar	3 Li Other (specify								
<u>۳</u>	Part II. Other significant conditions con	tributing to death but not re	sulting in t	he underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
Q p						1 □ Yes	2 □ No 3 □ Pro	bably 4 🛛 Unknown				
ete						04- 14	045 W					
mρ						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of				
ပိ						1 □Yes 2	No 1 ☐ Yes	2 🗆 No				
Be	25. Was case referred to medical examiner?	ospital:	_	- 1	Other:	eath (Check only one)						
<u>1</u> :	1 ☐ Yes 2 📉 No	28a. Date of Injury	☐ ER/Outp 28b. Tin	attent 3 DOA	4 LI Nursing	Home 5 A Residen		ify)				
ion	1 Natural 5 Pending	(Month, Day, Year)	Inju	ury V	njury at /ork?	28d. Describe how	injury occurred					
icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home form		Yes 2 No	Opt Leastion (Gt.	-1	18- 1-11				
iti	4 ☐ Homicide determined	building, etc. (Spec	cify)	r, street, factory, offic	е	City or Town,	et and Number or Rur State)	ai Houte Number,				
ٽ آ	29a. Certifier 1 X Certifying Phys	sician: To the best of my k	nowledge	death occurred at the	time date and als	uce, and due to the ac-	rea/e) and manner an	stated				
Medical Certification: To Be Completed by Physiclan/Medical Examiner		ner: On the basis of examination and manner stated.										
Mec	29b. Signature and title of certifier	and marrier stated.		29c. Lin	ense number	290	d. Date signed (Month,	Dav. Year)				
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	, Marin A	O Commit						, 2007				
	30. Name and address of person who con Alida Podrumar,			_{ype, Print)} n Drive, (	"umherlen	d, MD 215	02					
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e ir	31. Date filed (Mooth Day, Year) APR 17 200	9		barker								
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Sta Registra

State of Maryland / Department of Health and Mental Hygiene Miguel Chinchilla 2009 13569 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 11, 2009 0230 hrs **Medical Examiner** Miquel Chinchilla 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hvattsville Prince George's 8150 85th Avenue 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director None Country Guatemala 03/03/1978 1 X M 2 F 31 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location in, 10a. State 1 X Yes 2 No or 28a-f show Baltimore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene,
Important: If item 27 is marked other than "natural", or items 272 Prince George Brentwood Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3806 39th St Apt. 4 20722 Guatemala Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes 1X Yes 2 No specify: Guatemala specify: Hispanic Yes, Give Year Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miguel Chinchilla Jovelina Leal Ventura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maria de los Angeles Diaz/Wife 3806 39th St Apt 4 Brentwood, Md 20722 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial Cremation 3 Removal from State General Cemetery 04/20/09 Guatemala 22. Name and Address of Facility John T. Rhines Funeral Home Signature of Funeral Service Licenses 3005 12th. St. NE Washington DC 20017 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Gunhshot wound to the head Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other₄ Hospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 ✓ Yes 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot FOUND: Natural Yes 2 V No Pendina 24 hours after death Funeral Director: the Apr 11, 2009 0221 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 8150 15th Ave. , Hyattsville, MD determined (Specify) Sidewalk within 24 hor To the Fune completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated HA 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. egistrar's Signatu 31. Date filed (Monti State arka

DHMH 17 Rev 1/2001

Registra

**ORIGINAL** 

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#### State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jimmie Jean Dove PRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's 8. Date of Birth (Month 124, 1938) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 578-50-3321 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Modical Examinational be confided at once. Maryland Director Prince George's Berwyn Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8714 60th Avenue 20740 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Swartz Elsie Mae Raemsch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8714 60th Avenue Berwyn Heights, Maryland 20740 Eldridge P. Dove, Jr. -Husband OVE 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MD National Memorial Park 4/15/2009 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA Worseld 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final espirator **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Carcino ma Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi vance c Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 NO 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Man un of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2009

301

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

1 ☐ Yes

Day

2 🗆 No

Year

1 XYes 2 ☐ No

Washington, DC

White

State Registrar 30. Name and adde

Ame

31. Date filed (Month, Day, Year)

APP

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DHMH 17 Rev 1/2001

mpleted sause of death (Item 23a) (Type

P. Registrar's Signature

MDD6061

8 Good Leeck Rd., Lanham, MD.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Year MAXWELL 09 4c. County of Death 4b. City. Town, or Location of Death Garrell avid Oa If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1X M 2 ☐ F 86 Yrs. 13, 1922 Nov. 10b. County

1. Decedent's Name (First, Middle, Last) 1105 PM Physician 11201NG /Medical 4a. Facility Name (If not institution, give street and number, Examiner Samet County Memor & Hegy to Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** New York 578-20-3286 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 1 end 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene. ard 71 is marked other than "natural", or items 23a or 28e-f show the traumatic event, it a Maulical Examinate than the modified at or 28a-f show 1 ☐ Yes 2X No MD Swanton Garrett Be Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21561 2983 Turkey Neck Road United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ∏ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturers Representative Air Quality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Dewey Irving M. Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clark Day / Son 26 Walker Avenue, Gaithersburg, MD f Health itam 27 other tr 20b. Place of Disposition (Name of cometery, crematory or other pla Parklawn Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 1 X Burial 2 Cremation 3 Removal from State = 5 April 13, permit. Pege Depertment Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir lony arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ulmonary **Physician** Edema 72 hcs disease or condition resulting in death) /Medical consequend of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit atheroscleps P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physicism: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 2 ER/Outpatient 3 DOA Inpatient this After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending Fall 1 ☐ Yes 2 400 death. 2 Accident investigation completely filled in by the within 24 hours after deat To the Funers! Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Neusing Acres HC 60 Box 98 METALLA Detlava Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Margaret a KAISER, MD D26650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 888 Men onial ser, md invigaret a Ka 31. Date filed (Month, Day, Year) 32/Registrar's Signature State APR 14 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended, #7, #8, For TCHD, 04/14/2009, TLS State of Maryland / Department of Health and Mental Hygiene AMENDED, # For TCHD, 04/14/2009, TLS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 640 P TRONG 6 25 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mary Cester land If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 62 Months Days Hours Min 1**XX**M 2□ F 215-44-7196 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Evenings must be notified at Director 1 ☐ Yes XX No TALBOT ROYAL OAK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21662 24921 DEEP NECK RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 150 es 2 □ No In es, Give Year or Dates:1966-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XXVo Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT CARPENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked oth Be ANNA D. HORNEY GEORGE O. DAFFIN, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i FEDERALSBURG, MD 21632 SON 25959 AUCTION RD. ROBERT W. DAFFIN, SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4-11-2009 STEVENSVILLE, MD Signature of Funeral Service Licensee Name and Address of Fa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MOHO K. MERCEROP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Intra Canis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Phyalcian: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier

6RK

State 31. Da Registrar

31. Date filed (Month, Day, Year)

19.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

back

		•	For State Registrar			,	Cer	tificate of	Death		Reg. No.	2009	13573
	Physicia	an	1. Decedent's Name		st)	DAVIS				2. Date of Dea	Day	Year	3. Time of Death 10:20 <b>A</b> M
	/Medic	al			re street and number			4b. City, Town, o	r Location of Death	APRIL	11 4c. 0	2009 County of Death	<del></del>
	Examin	er			AND HOSPI			CLINTO				INCE GE	
	Funeral Director		5. Social Security N 239-66-2	156 6. 9	Sex 7. A 1 ☐ M 2 ☐ F	ge (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da FEB 2	th y, Year) -1941	COL	place (State or Foreign intry) CH CAROLINA
land	wo.		Usual Residence of 10a. State	10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
Mary	a-f sh	ctor	DC			WAS	SHIN	GTON					1 X Yes 2 □ No
h with the	23a or 28	Funeral Director	10e. Street and Nur 1418 BUC		REET N.W.			10f. Zip Code 2001	11		10g. Citiz USA	en of What Coเ	untry?
Q Z IZ I 3-0030 filed within 72 hours after death with the Maryland	if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evandor must be notified at	by	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2☐ Married 4☐ Divorced	12. Was Deceden Armed Forces 1 □ Yes 24 If Yes, Give Year or Dates	?		Nas Decedent of H fYes, specify Cub I □Yes 2 🟋No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		4. Race - Amer Black, White Specify: BI	, etc. ACK
<b>16.13-</b> 0-c13-ithin 72 hc	ne. han "natul Mudical	Completed	Elementary/Seco	15. Decedent's E cify only highest gr ndary (0-12)	ducation ade completed) College (1-4or	5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire K DRIVER	oation during most of work d)	king		d of Business/I	ndustry
<b>e</b>	nd Mental Hygiene. marked other than imatic event, ith	To Be Co	9th 17. Father's Name LEVI D	(First, Middle, Las	t)		IKOO	K DRIVER	18. Mother's Nam HELEN			Surname)	
, Maryla and 2 should I	lealth and M m 27 is mar her traumat	-	19a. Informant's Na LINDA CH	ame/Relationship IEEK /DAU	(Type. Print) GHTER	15	9b. Mailir 1171	ng Address <i>(Street</i> 1 TROY CO	and Number or Ru OURT WALD	oral Route Numb ORF, MA	er City or RYLAN	10 ^{wn} 28faf67	ip Code)
S - S	Department of Heal Important: If item 2 any Injury or other Once.				Removal from Stat	como	tory crar	sition (Name of matory or other pla MBY CEME	rery 4/18		FOUN		ORTH CAROLINA
	Department Important; If any Injury or once.		21. Signature of F	~ 04	2		7		OVER ROAD	LANDOV	ER,MA		RAL HOME 20785
-)/	nysician Medical xaminer		shock, or hea Immediate Cause disease or condition resulting in death)	art fallure. List only (Final on	nplications that caus one cause on each a. Due to 7 ra	ed the death. D line.	lun	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
b&/bU, rtificate be executed	physician and the burial-transit	sal Examiner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events resulting in death)		c	s a conse juend							
ords, F.O. Box 68, requires that the death certificat	attendi for use	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [ 9 □ Unknown	months?		2 Fetal dea		□ Ectopic pregnan □ Other <i>(specify)</i> _	су		2	23d. Date of del Month	ivery Day Year
ouires that	s been signed by the should be detached		Part II. Other signi	ficant conditions	contributing to death	but not resulting	in the u	nderlying cause gi	ven in Part I.		tobacco u Yes 2[		the cause of death?
( ) ~	11 70	Completed by	Hyperr	viteem	ice, el	moci	idea	us, Hy	jeolensia	24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	itopsy findings available completion of cause of 2 ⊠No
VITA	certific rector,	Be	25. Was case referexaminer?		Hospital:			Ott	26. Place of Dea				
VISION OT Attending Phys	th. After this funeral di	ertification: To	1 Yes 2 ☐  27. Manne Deal  1 atural 2 ☐ Accident		28a. Date of li	ntient 2 ER/ njury 28t Day, Year)	outpatie Time o Injury	f 28c. Inju	4 Li Nui sing r	lome 5 ☐ Res 28d. Describe			ciry)
UIVISION al or Attending	s after dea Il Director ed in by the	Sertifica	3 Suicide 4 Homicide	6 Could not determine	28e. Place of building,	njury - At home, etc. (Specify)	farm, st	reet, factory, office		28f. Location ( City or To			ural Route Number,
he Hospita	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.9	Medical C	29a. Certifier (Check only one)	1 Certifying F	Physician: To the be aminer: On the basis and manner	of examination	dge, deat and/or ir	th occurred at the nivestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	, date and	place, and due	e to the cause(s)
		N	29b. Signature and	title of certifier	aintar	. , M	D	29c. Licen	se number QU 28°	7	29d. Dat	e signed (Mont	h, Day, Year)
	3		30. Name and add		o completed cause o				OT TARROTT	MADIT 13	TD	0725	
	Sta Regist	ate rar	VARSH 31. Date filed (Mor		32. Regi	7503 SU strar's Signature	-		CLINTON,	MARYLAN	<u>iD 2</u>	0735	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month **№** M **Physician** 1210 William Howard Dunkin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 212-38-9585 1 □ M 2 □ F 70 11-4-1938 MD Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedfool Event in the Item 27 is notified at once. 10a State MD Washington Hagerstown X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 252 S. Burhans Blvd. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 _{Specify:}white 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) city park Elementary/Secondary (0-12) College (1-4or 5+) caretaker 5th grade 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Corrine Diffenderfer Maurice LeRoy Dunkin Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4331 Timber Ridge Rd. Needmore PA 17238 Douglas J. Dunkin son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Damascus Church Cem. 4-18^{pate} 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Needmore, PA 2009 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer P105 Immediate Cause (Final (al 0.5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsi Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Ye ar in the past 12 months? 5 ☐ Other (specify) the 1 TYPS 2 No. 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown been si should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Division 1 Natural 1 □ Yes 2 □ No death. I hours after death.

uneral Director: A

sly filled in by the fu 2 🖺 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO60396 04

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARID

31. Date filed (Month

JR SHED

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** David A. DeBell 2009 April 06, 10:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 266 Lower Magothy Beach Road Severna Park 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours New York 76 Sept.05,1932 052-32-7797 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Anne Arundel Severna Park MD 1 ☐ Yes 2 ▼No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 266 Lower Magothy Beach Road 21146 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mayes 2 □ No 1956—
If Yes, Give
Year or Dates: 1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2X No Specify: ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Radar Systems Engineer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Wadsworth Hasbrouck George William DeBell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 266 Lower Magothy Beach Road Severna Park, MD 21146 Penny DeBell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date April 13 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cemetery 2009 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARDIOAN Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 'sntreciala Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 □No hin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔛 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 04-06-2009 HID, Anegrala, Nep 2:801 30. Name and address sof person who completed cause of death (Item 23a) (Type, Print) scelkin ul 200 plage 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Laura Diallo	

ıra Diallo	1-	Stat For State	e of Maryland / Depar	rtment of <i>tificate of</i>		Mental Hy	giene Reg.	No. 20	09   357
Physician/		gistrar Decedent's Name (First, Middle,I		,			2. Date of Death	av Year	3. Time of Death 1900 hrs
edical Examine	r	Laura Si	tern //a/10	,	4b. City, Town, or Lo	nestion of Death	April 20, 200	4c. County of Dea	
	48	a. Facility Name (if not institution, 7802 Marion Lane	give street and number)	ľ	Bethesda	ocation of Death		Montgomery	
Funeral	5.		. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (	MM/DD/YYYY) 9. I	Birthplace (State or
Director			I M 2XF 58	Yrs	Months Days	Hours Min.	3/27	/5/	eign Country) New York
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or items 23		Never Married 2 Man	ried Armed Forces?	If Y	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc	11/
her de		3 Widowed 4 Divor	1 Yes 2 No	1	Yes 2 X No			Specify: 4	Mite
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6 n 72 h an "n ical E		Elementary/Secondary (0-12)	College (1-4 or 5+)			/		Pauch	1000
5-0036 lied within 7 Hygiene. I other than the Medica	nanaldwo 1	7. Father's Name, (First, Middle, L	act)		hera pis	8.Mother's Name	(First, Middle, Ma	ajden Surname)	01099
215- be filed ntal Hyg rrked of			p.n			Minna	Gill	ert	
ID 21215-00; should be filed with and Mental Hygiene if is marked other timatic event, the Med To Be Com		9a. Informant's Name/Relationshi	p (Type, Print )	19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City or Town, S	tate, Zip Code)
and 2 shou lealth and N tem 27 is n traumatic	L	Carl Stein	Brother	322	Sked	St Teni	nington	20c. Location - City	or Town State
Baltimore, M permit. Pages I and 2 Department of Health Important: If Item 2 injury or other traur		0a. Method of Disposition  1 Burial 2 Cremation	3 Removal from State 20b. I	Place of Dispo crematory or o	sition (Name of cent ther place)	netery,	Date	200. Eddallon - City	/ 11. 4 //
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Baltimore, permit. Pages 1 at Department of He. Important: If ite	2	1. Signature of Furieral Service L	icensee	22.	Name and Address	Facility Pag	uside Fo	Alu III	ME HÜ
	- France	And W. J	complications that caused the death	Do not enter	the mode of dying,	n.S. DIVCI. such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval
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		Sequentially list conditions,	b						
	ine	f any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):					
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Box 68761 e death certificate the attending phy ted for use as the beat of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	icia	past 12 months?	4 Pregnant at time of de	eath 5 (	Other (Specify)				
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aw rechast be	Completed							med? dea	
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of Vital Recing Physician: The Land After this certificate I funeral director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatie		lou.		Residence 6	Other: Scene
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nding th.	<u>Ö</u>	1 Natural 5 Pend		Fd 6:	45 pm 1	Yes 2X No		ed medica	
l or Attend after death. Director:	icat		d not be 28e. Place of Injury - At I			building, etc.	28f. Location (3 or Town, S	Street and Number	or Rural Route Number, City Marion Lane
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:		rmined (Specify) house				Bethesd	a, MD	
Hospital 24 hours Funeral etely filled		29a. Certifier 1 Certifying Pl	hysician: To the best of my knowle	edge, death occ	curred at the time, d	ate and place, an	d due to the caus	se(s) and manner a	s stated.
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif	g	one) 2 Medical Exa	miner: On the basis of examination and manner stated.	gation, in my opinion	n, death occurred	at the time, date	and place, and due	e to the cause(s)	
29b. Signature and title of certifier						se number			(Month, Day, Year)
		tamely du	thall, mi)		0.0	.M.E. 		April 21, 200	<u> </u>
20	ŀ		who completed cause of death (Ite		111 Penn Stree	et Baltimore	MD 21201		
EL.		Pamela E. Southall, N				, Dailinole,	11.0 2 1201		
	ate rar	31. Date filed (Month, Day, Year) APR 2 3 20	32. Registrar's Signa	Sack					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician 2009 9:08 A M April Victor Thomas Emanue1 William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 935 Marion St. Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye. Dec. 31, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1 X M 2 □ F New York 1929 79 Director 134-26-1049 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Examinar must be notified at 1 ∏Yes 2 □ No Director MD Washington Hagerstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic event once. U.S.A. 935 Marion St. 21742 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Black, White, etc. 1 Never Married 2 M Married 1 □ Yes 2 X No Specify. If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Transit Authority 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vanito Emanuel Beatrice Jacobs ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William G. Emanuel/Son 935 Marion St., Hagerstown, MD 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4/17/2009 Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sign were of Funeral Service icens <u>1601 Pennsylvania Ave., Hagerstown, MD</u> 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MeFashbr **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier .13.05 041667

Registrar DHMH 17 Rev 1/2001

3H-0+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

meck

11110 32. Redistrar's Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryla		artment of F r <i>tificate of I</i>		_	giene Reg. No. 🔿 🕜			
			Registrar  1. Decedent's Name (First, Middle, Last)		imouto or i		2. Date of Death  Month  Day  Vegr  Vegr				
	Physicia /Medic		ISMAEL VALLEJO ESCOBAR				APRIL	20	2009	10:50 AM	
	Examin	er	4a. Facility Name (If not institution, give street and number)  CIVISTA MEDICAL CENTER	2	4b. City, Town, or	r Location of Death			nty of Death	ā	
-47	Funeral		5. Social Security Number 6. Sex 7. Age (In )	vrs. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da			lace (State or Foreign trv)	
	Director		585-01-2927 ¹ \(\overline{\text{X}}\) M 2□ F	90 Yrs.	Months Days	Tiouis Willi,	6-17-	1918	SPÄI	N	
	/land			City, Town or Lo					10	0d. Inside City Limits	
~	e Mar	ctor	MD. CHARLES		LA PI	JATA				1 X Yes 2 No	
23849	death with the Maryland rms 23a or 28a-f show r.nwat be notified at	Funeral Director	10.1.2 CHEERICD ACC CIDCLE		10f. Zip Code 206	16		10g. Citizen o		try?	
E	ms 23	neral	1013         SWEETGRASS         CIRCLE           11. Marital Status         12. Was Decedent Ever in	n U.S. 13. \		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No		Race - Americ		
4 <i>EL #4</i> 215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the World Evand or must be notified at once.		1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 🎇 No	an, Mexican, Puerto Specify:	Hican, etc.)		Black, White, e		
E7 15-0	72 ho "natur	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of work d)	ing		Business/Ind	-	
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Sp	be filed htal Hyg ed other event, I	Be C	17. Father's Name (First, Middle, Last)	2,00		18. Mother's Nam		Maiden Surn	ame)		
$\mathcal{IS}$	should b and Ment s marked umatic e	2	ISAAC ESCOBAR				VALLEJ				
Mai	id 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (Type. Print) MARIA ELIZ. ESCOBAR-DAUGH	I	•	and Number or Ru FGRASS C					
Je,	s 1 and of Health item 27 other t		20a. Method of Disposition 20	h Place of Disno		1	Date		n - City or To		
$ESC_{0}$ Baltimor	Pages ment of tant: If it lury or o			ROPOLIT	CAN CREM	MATORY 4	-23-09	ALEX	.,VA.		
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee M00479	F	2. Name and Addre RAYMOND LA PLATA	ss of Facility FUNERAL A, MD. 20	SERVI 646	CE,P.	Α.	Ę	
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	10	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
The same	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1/1	Ditato	y for	; Kur	<u> </u>			
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•	execute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.	sequence of):	- Treat	C Pr	1 9007	<u></u>			
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89 x		Med	IF FEMALE:								
Box	leath certifi attending   for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pre 1	etal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	ey .		- 1	Date of delive Month	ery Day Year	
	nt the oby the tached	hysi	1   Yes 2   No 9   Unknown 9   Unknown						,		
Division of Vital Records, P.O	quires than signed and be de	þ	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did t			ne cause of death?	
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Divi	lor Al after o Direc	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	at nome, tarm, str ecify)	eet, ractory, onice		City or To		mper or Hura	l Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.								
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)	
	;		I fyllal the		D.	37174		4/:	20/3	009	
			30. Name and address of person who completed cause of death SONG C. CHON, M.D., 7C POSTO			NOFIAN	20122	(	/	,	
	Sta	te	31. Date filed (Month, Day) Year) 32. Registrar's S	gnature	A WALD	UM, MU					
	Registr	ar		Ray ou w							

Registrar

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Registrar DHMH 17 Rev 1/2001

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Box 68760

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Division of Vital Records,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** PM George William Finch III April 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign Country) District If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 ★ M 2 🗆 F 55 April 8,1954 of Columbia Director 217-64-8322 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it. "safest Express. "ust be notified at ury or other traumatic event, it." safest Express. 1 ☐ Yes 2 ☑ No Director MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1590 Kimblewick Road 20854 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Church Priest 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George William Finch Jr. Barbara Rawlings မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Finch / Mother 12092 Neale Sound Drive, Cobb Island, MD 20625 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o April 14 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, MD 21. Signature of Funeral Service 22. Name and Address of Facility TRACY DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 208/7 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic Coronary Artery Disease Examiner Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) director, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 🔲 Inpatient 2X ER/Outpatient 3 □ DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. To the within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier GEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical 790 ente 22. Registrar's Signature

Registra DHMH 17 Rev 1/200

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year APRIL 2.55P M **Physician** 2009 Farber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Burtonsville Holy Cross Nursing and Rehab | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/13/1946 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Yrs PA 62 Director 579-62-1292 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other then "natural", or Items 23a or 28s-f ehow traumatic event, the Madical Examiner must be notified at 1 XYes 2 No Silver Spring MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20905 United States 1 Butterchurn Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 🏋 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Health and Mental Elizabeth Berger Paul Lebovic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Butterchurn Court Silver Spring MD 20905 Richard Farber - Husband f Health item 27 important: If item eny injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 4/13/09 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sage Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 M01163 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) BREAST CANCER METASTATIC Physician /Medical Due to (or as a consequence of): METASJASIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificete be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pr → ant in the past 12 115 ths?
1 □ Yes → No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not regulating in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORDER SEIZURB 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an 2 No 22 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of eath Check only one Be Hospitaf: Other: 1 ☐ Yes 22No ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manne Death neral Director: After the filled in by the funeral 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 14 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rowell

29b. Signature and title of certifier

TASNEEM



allain

D 28595

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SUITE

			For State Registrar		State of M	ai yiai iu i	•	tificate of			eniai riy	Reg. N	- 6 U	09	13582
	Physici	an	1. Decedent's Nam	e (First, Middle, La	st)				~		2. Date of Do Month		Day	Year	3. Time of Death
	/Medi				James	Marior	1	Fox			April			2009	1:19 A M
	Examir	ner	4a. Facility Name (	If not institution, gi	e street and number	)		4b. City, Town, o				4	lc. County		
Y					al Hospit		( : (	Frede		er 24 Hrs.	O Data of B	uélo.		deric	Place (State or Foreign
	Funeral Director		5. Social Security N 220-42-56 Usual Residence o	529	Sex 7. Ag	ge (In yrs. last	Yrs.	Months Days		Min.	8. Date of Bi (Month, D ov • 19	ay, Yea	943	Mary	ntry) 'land
	and and		10a. State	10b. County		10c. City, To	own or Lo	cation						1	10d. Inside City Limits
	Mary f sh	φ	Maryland	Frederi	ck	Thur	mont								1 ☐Yes 2 ☐ No
	28a	rec	10e. Street and Nu	L	CK	Indi	mone	10f. Zip Code				10g. (	Citizen of N	What Cou	ntry?
	3a or	0	100 Mount	tain View	Place			2178	8				U.S.A	۸.	
	death ms 2	ner	11. Marital Status		12. Was Decedent	Ever in U.S.	13.	Vas Decedent of f Yes, specify Cub	Hispanic (	Origin? (Spec	cify Yes or N	0-			can Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Evaraine roust be notified at	Completed by Funeral Director	1 Never Marr	ied Married 4 Divorced	Armed Forces? 12 Yes 2 ☐ If Yes, Give Year or Dates:	No		ryes, specify Cub □Yes 2 XNo			(Ican, etc.)		Specify	^{v:} White,	
9-0	2 ho	ted	(500	15. Decedent's E	ducation	1	6a. Dece	lent's Usual Occu	pation	act of warkin	~	16b.	Kind of B	usiness/In	idustry
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pu	e file	Be (	17. Father's Name	•	)					ther's Name	•	e, Maid	en Surnan	ne)	
/a	Ment Ment arked	은	Glen E.	Fox					Ma	ary Br	own				
, Maryland	and 2 sho raith and 27 is ma er trauma		19a. Informant's N Ann M. Fo		(Type. Print)	1		g Address <i>(Stree</i> Mountain							p Code) and 21788
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maribal Evantmer must be notified at once.			•	Removal from State			sition <i>(Name of</i> natory or other pla emetery	ice)	Da 4/14/	nte 09	!		_	own, State ryland
Balt	permit. Departr Imports any Inje		21. Signature of Fr	uperal Service Lice	See De Cost	1	R 6	Name and Addr OBERT E. 15 EAST	ess of Eac DATI MAIN	EY & STREE	SON FU	NER.	AL HO	MES,	P.A. 788
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isi	deatl deatl ctor; y the	ical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b	e 200 Blood of In	iurv - At home	. farm. str	eet, factory, office	1169 61		8f. Location	(Street	and Numi	per or Bur	al Route Number.
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_	To the Hospital or Attendil within 24 hours after death.  To the Funeral Director; A completely filled in by the fu		29a. Certifier (Check only	1 ☐ Certifying P	hysician: To the best miner: On the basis	of my knowle	dge, death	n occurred at the t	time, date	and place, a	nd due to the	e cause	e(s) and m	anner as a	stated.
	the Prin 24	Medical	one)		and manner st	tated.									
	Vith Vith Con	2	29b. Signature and	I title of certifier				29c. Licen	se numbe	1/1/0	)				Day, Year)
			•						2//				4/1	0/0)	7
	6+1		30. Name and add	ress of reason who	completed cause of	death (Item 23	a) (Type,	Print)							
	-		William	F. Harpe	r, MD 180			nson Dr	ive,	Suite	101,	Fre	deric	k, M	D 21702
,	Sta		31. Date filed (Mor	APR 1 4	32. Regist	rar's Signature		arked							
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 April **Physician** 6:20 P M 11, Gruner Wayne R. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 444 Russell Avenue Gaithersburg Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 X M 2 □ F May 31, Minnesota 87 1921 Director 476-18-3039 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, If a Madical Exprisive must be coulfind a once. 1X Yes 2 □ No Director Gaithersburg Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20877 Funeral 444 Russell Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑Yes 2 □ No 1944-If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 1 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garrett Gruner Opal မ John Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sarah A. Gruner/Wife 444 Russell Avenue, Gaithersburg, Maryland 20877 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/13/2009 | Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Weeks Cardiac Rhythm Disturbance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Years <u>Hyperlipidemia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed 2 Years H ergl cemia burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Recent drug treatment with Namenda 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 No Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, par Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 512 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the ...
within 24 hours anc..
To the Funeral Direct
'~elv filled in by

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Road, # 100, Bethesda, Maryland 20817 McNamara, M.D., Thomas J. 31. Date filed (Month, Day, Year)

ancera

and manner stated.

29a. Certifier (Check only one)

29b Signature and

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 32610

29d. Date signed (Month, Day, Year)

April 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ,2009 **Physician** 752 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery The Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Countraine Days 69757799 1**√** M 2□ F 89 220-41-8504 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 XYes 2 No Be Completed by Funeral Director Rockville MD Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20852 6121 Montrose Road 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosalia Kazarinskaya Schlomo Gorbatyi ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3949 Ballet Way Burtonsville MD 20866 19a. Informant's Name/Relationship (Type. Print) Nataliya Gorbataya Grand-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesed Shel Emmes Cem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/13/09 Capital Heights, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Edward Adwess of Farineral Direction Inc. 1097 Rockville Pike Rockville MD 20852 M01163 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause yeach line. Immediate Cause (Final disease or condition resulting in death) CLILAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 University Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, director, page 2 should be detact To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

**Examiner** 

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ceptifier

29c. License number D 35436

29d. Date signed (Month, Day, Year) APRIL 09, 2009

cause of death (Item 23a) (Type, Print) Barbara Kalazny, M.D. 2 30. Name, and address of person who compl

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Medical

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician April 11, 2009 05:50 AM Eugene Francis Gillespie, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Golden Living Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1'**⋈** M 2□ F 82 Director 161-20-8640 November 29, 1926 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show la or 28a-f sh t be notified a 1 ¥Yes 2 □ No Director LaVale Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 Yeoman Court U.S.A 23a 21502-7 Is marked other than "natural", or items 23a traumatic event, the Medi∗al Exaπlner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No WW II
If Yes, Give Korea
Year or Dates: Vict Nam Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 M2 No Specify. Specify: ģ 3 ₩ Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United State Air Force military 12 12 should be filed with and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna Lucinda McCann Eugene F. Gillespie, Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 Is any Injury or other trau 21502-Maryland Eugene C. Gillespie 3 Yeoman Court LaVale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 18, 2009 4 □ Donation 5 □ Other (Specify) Lompoc Cemetery Lompoc California 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical for as a consequence of). Examiner CODO Sequentially list conditions, if any, leading to immediate cause. Enter onder, mg Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did topacco use contribute to the cause of death? <u>ک</u> 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No 24a. Was an has page 2 autopsy perform certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Matural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14+ erson who completed cause of death (Item 23a) (Type, Print) mal Memorial Ave. M.A. Cumberland

Registrar DHMH 17 Rev 1/2001

State

500

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:55P^M Francis William Germaine 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Care & Rehabilitation Center Crofton Anne Arundel 7. Age (In yrs. last birthday) | ff Under 1 Year | If Under 24 Hrs. | O I. | Vrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Year) June 28, 1924 5. Social Security Number **Funeral** 1 ★M 2 F 149-18-1580 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Acial Eventhal Frontial and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XX yes 2 □ No Director Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 Wakefield Lane 20715 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 👿 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Compliance Inspector APHIS-USDA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Germaine Rose Wolf ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cecilia Ann Germaine 4000 Wakefield Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Catholic 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Gemetery 0.

22. Name and Address of Facility 04/14/2009 Bowie, Maryland Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of: Examiner that the death certificate be executed sician and burial-trant Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.0. detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Non-Insulin Dependent Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy perform 2 **X** No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00029571 04/09/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul B. Berez mo 2225E Defense Hny, Crofton, MD 21114 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelingthink/ 25750 reall Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>09</u> Physician  $A^{\,\mathsf{M}}$ HOLLOWAY March 23, WALLACE 8:33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <del>7221-Klovstad-Drive</del> 7721 Klovstad Dr Prince George's Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Sex 1 M 2 □ F **Funeral** 248-22-4213 Director May 16 1921 Edgeville, SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f short welfcal Examiner must be notified at MD Prince George's Director Ft. Washington 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Klovstad Drive 20744 USA 7721-Kovstad-Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Black ð 3 ☐ Widowed 4 1 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Italy once. Truck Driver VA Correction Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Holloway Martha Curry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7721 Klovstad Drive, Ft. Washington MD 20744 19a. Informant's Name/Relationship (Type, Print) Michael Holloway/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/2009 Arlington Natl. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 22. Name and Address of Facility Pinckney-Spangler FH 21. Signature of Funeral Service Licensee ▶Theodore C. Pinkney per DVR 524 8th St. NE, Washington DC 20002-5236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest minutes /Medical Examiner Multi System Chronic Disease Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Prosthetic hip 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed Severe Arthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Hospital or Attending Physician: The certificate 2K No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ca 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examination And the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature a

title of ce

31. Date filed (Month, Day, Year)

32. Registra s Signature

and manner stated.

within 2 To the I

30. Name and add as of person who completed cause of death (Item 23a) (Type, Print)

J. Malouf MD FACEP, Internal Medicine Clinic, 1050 W Perimeter Rd 20762

42880 29d. Date signed (Month, Day, Year)

09-02585 Willie Hill. Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ie Hill, Jr.	1. 6	State of Maryland / Department of Health and Meritai Hygic For State Certificate of Death	Reg. No.	201	9 1358
Distriction	Dor	egistrar 2. Decedent's Name (First, Middle,Last)	ate of Death		Time of Death 1515 hrs
/Physician Examine احتناط		WILLIE JAMES HILL JR	oril 1, 2009	c. County of Death	15151115
	4a	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville		Montgomery	
	Ĺ	Shady Grove Advertist Flospital	Date of Birth (MM	A/DD/YYYY) 9. Birthp	lace (State or
Funeral		Months Days Hours Min.	Jan. 1	, 0.0.9	ry) DC
Director	-	7,5 ,1 = 0.0 = 1,5 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1 ,1	J 411 0 = 1		0d. Inside City Limits
any		Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		1	1 X Yes 2 No
≥		MD Montgomery Montgomery Village	10g C	itizen of What Countr	
the Maryland a or 28a-f show tified at once.	10	10e. Street and Number	10g. C	U.S.A.	,
death with the Maryland or items 23a or 28a-f shounst be notified at once.		9306 Jarrett Court 20886	v Yes or No-	14. Race - America	an Indian, Black,
or items 23	1 1	11. Martial Salus Married Armed Forces?	an, etc.)	White, etc.	
er dea		2 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Bla	
urs aft tural' amine	ਤ⊢	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)		. Kind of Business/In-	dustry
72 ho		Elementary/Secondary (0-12) College (1-4 or 5+)		Home	
within giene.	Completed	9 CTI 18.Mother's Name (Fi			
115-115-1 al Hyg	ရှိ   '	Sniri	ey Ann	Green	Zin Ondo)
MD 21215-0036 d.2 should be filed within 7 and Mental Hygiene. In 27 is marked other than annatic event, the Medical annatic event, the Andical Control of the Annatal Control of the A		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of Rura	al Route Number,	age. MD	20886
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once	L	Kilonda B. Hara	Date 20	c. Location - City or	Γown, State
ore, sslan of Hea Fiter	2	1 Burbal 2 X Cremation 3 Removal from State crematory or other place)	/09	Hanover,	MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		4 / Dolgation 5 Other opening	wen	uneral	offe,
Ball permit Depar Impor injury	- 11	1 246 N. Washingto	on St R	SOCKATITE	,MD20830
Physician	1	3a. Part I. Enter the disease, complications that caused the dust. Do not enter the mode of dying, such as cardiac or refailure. List inly one cause on each line.	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Medical		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Beaut
.aminer		or condition resulting in death)  Due to (or as a consequence of):			
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	튑	cause. Enter Underlying Cause (Disease or injury that initiated			-
Busit ed &	Щ	events resulting in death) Last Due to (or as a consequence or).			-
e be executed ysician and burial - transit	ledical	UNPENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 1 I be birth 2 Fetal death 3	су	23d. Date of deliver Month	y Day Year
O. Box 6876 that the death certificate and by the attending phy detached for use as the l	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)			
Box e death c the atten	ysic	1 Yes 2 No 9 Unknown 9 Unknown	23e. Did toba	acco use contribute to	the cause of death?
P.O. I					bably 4 🗸 Unknown
S, P.C	q pa	Chronic alcohol abuse; status post resection of brain tumor	24a. Was an		utopsy findings available completion of cause of
ords, w requir	plet		autopsy perform	ned? death?	,
Rec The Is icate h	Completed by	26.Place of Death (Check o	100		
Vital Recc ysician: The lav his certificate ha	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing		tesidence 6 Oth	er:
1 of Vi ding Phys After this funeral di	-T	1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
on C anding art. Af	tion	1 V Natural 5 Pending 1 Yes 2 No		to at and Number or F	Rural Route Number, City
Division of Vital Records, tal or attending Physician: The law requir us after death.  Al Director: After this certificate has been selled in by the funeral director, page 2 should	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Sta		tural reduce realises, only
Dipital ours at filled	Cert	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as st	ated.
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the			it the time, date a	and place, and due to	the cause(s)
To the within To the comple	Medical	and manner stated.  29c. License number  29b. Signature and title of certifier		29d. Date signed (A	fonth, Day, Year)
		O.C.M.E.		April 2, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Potricio Archica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimor	MD 24204		
			e, IVID Z IZU	1	
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor  e 31. Date filed (Mooth DawYear) 2009 33 Registrars Signature			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death A Month 3:54 PM Betty Ann Highsmith 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F Months Days Hours Min. 75 578-46-6114 4/14/1933 Washington, D.C Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Yes 2□No Maryland | Prince George's New Carrollton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8303 Sprague Place 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried If Yes, Give Year or Dates: 1 □Yes 27 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Prince George County College (1-4or 5+) Hearing & Vision Technician Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph McFadden Emma H. Sherwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8303 Sprague Place, New Carrollton, Md 20784 Horace E. Highsmith/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Brentwood, Maryland Fort Lincoln 04-09-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 12L Price 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCICIENTIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events Due to (or as a consequence of): ਸ਼ਾਕ ਜਾਸ਼ਿਕਾਦਰ events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HAPONTONINA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1No THROMBOSIS 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner law requires that the death certificate be executed burial-transi and Division of Vital Records, P.O. Box 68760, attending physician the as use for the þ signed I been si should b icate has l , page 2 s The certificate

Examine Physician/Medical δ Completed director, Be this Certification: To After th funeral death. n 24 hours after death.

• Funeral Director: A

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examine sust be norther.

**Physician** 

/Medical

Medical within 24 hor To the Fune completely fi State Registrar

Hospital or Attending

29b. Signature and title of

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

MASUR 31. Date filed (Month, Day, Year) APR 13

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 755559 7525 4123 32 Registrar's Signatur WEELS12

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1:25 AM Danie1 Ellis Howe 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) v 23,1933 **Funeral** Min. Months Days Hours 11√2 M 2□ F February 76 Director 170-26-3067 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show artment of Health and Mental Hygiene.

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, Item Modical Examinations and be notified at Director 1 TYPes 2 □ No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 12105 Tanglewood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 150-170 1 ☐ Yes 2▼ No Specify White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NASA Computer Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Bloom Issac Wilbur Howe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Fleming Lane Bowie, MD 20715 Dawn Marconi/ Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or conce. 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4/12/2009 Waldorf, MD 5 ☐ Other (Specify) Huntt Crematory 4 ☐ Donation 21. Signature of Funeral Service Licen 22. Name and Address of Facility Robert E. Evans Fuenral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I Yes 2 □ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2- No Hospital or Attending Physician;
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 - HO 1 [1] Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

32. Registrar's Signature Denve S. park

14300 Gallan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

130WIE, MD 20715

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			1- For State Registrar		ificate of D	eath	[2 Da	Reg. No.	200	3. Time of Death
Me	Physicia dical Exami		1. Decedent's Name (First, Middle,Las	11 1 0 .			l Mc	onth Day ril 20, 2009	Year	0620 hrs
			4a. Facility Name (if not institution, give	1 11 11 11	4b.	City, Town, or Location		4c.	County of Death	_
			Washington County Hosp			Hagerstown			/ashington	
	Funeral Director		5. Social Security Number 6. S 232-94-7685	ex 7. Age (In yrs. las		If Under 1 Year If Ur Months Days Ho		Date of Birth (MM/I	Enreig	Intry) (1)
	ý		Usual Residence of Decedent  10a. State 10b. County	10c City I	own or Location					10d. Inside City Limits
	i now any e.		1.11/ 10.	12.1	1 5	1				1 Yes 2 No
	aryland 8a-f sh at onc	g	10e. Street and Number	in Devi	Election	of, Zip Code		10g. Citiz	zen of What Cour	itry?
n	ith the Maryland 23a or 28a-f show notified at once.	Director	5054 Pines R	idea Rd	11	25411			USA	
6	with ms 23. be no	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was E	Decedent of Hispanic C	Origin? (Specify	Yes or No-	14. Race - Americ	can Indian, Black,
1	r death or ite	E.	1 Never Married 2 Marrie	1 Yes 2 No				Ì	. 1 1	1. 1
	rs afte nral", miner	<u>چ</u>	3 Widowed 4 Divorce  15. Decedent's Education (Specify of	d If Yes, Give Year ( or Dates:		es 2 No spec Usual Occupation (Gi			Specify: U	ndustry
	72 hou "nat	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		of working life. DO N				<i>C</i> 1
	5-0036 iled within 77 Hygiene. I other than	Completed			mach	ine One	prator		Jean	(lur_
	more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shu rucher traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Las	1 1 0		١٨١	1	t, Middle, Maiden	0 1	1110
	2121 ould be fi Mental I marked c event,	To Be	19a. Informant's lame/Relationship (	Type, Print)	19b. Mailing A	ddress (Ştreet and N	Number of Rural	Route Number, Ci	ity or Town, State	Zip ode)
	MD 2 d 2 shot lth and I n 27 is r		Joseph F	John Father	Box 518	ddress (Street and N	ida Rd	Berkeley	Springs	25411
	re, n 1 and Healt Fitem		20a. Method of Disposition		lace of Disposition	on (Name of cemetery,	, Dat	e 20c.	Location - City or	Town, State
			1 Burial 2 Cremation 3 4 Donation 5 Other Specific	Tremoval noin white		Am. F.	14 4-23	3-09 Sm	ithshur	g. Md.
	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death wi Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be		21. Signature of Funeral Service Lice			e and Address of Face	rson Fui	neral H	ome	1.
			24 Part I Enter the disease or com	plications that caused the death.	1 1 1 1 1 1 1	TVI KOVILT	1 1 1 1 1 2 2 1 1 1	11111	V 20 1	Approximate Interval
	Physician /Medical		failure List only one cause on e	each line.  Hypertensive a						Between Onset and Death
9	xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of		Terotic Ca	ardiovas	Culul us		
			Sequentially list conditions,	).						
		xaminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	y.					ĺ
	d sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):					
	ecuted and trans	ш		222 27	nerME. 9	892 6/3/09	9 TT			
	O, e be ex ysician burial	cian/Medical	X UNPENDED	, AMERICES				23	d. Date of deliver	
	Box 68760, c death certificate but the attending physic of for use as the bur	M/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr		death 3 Ect	topic pregnancy	120		Day Year
	ath cer attendi	S.	1 Yes 2 No 9 Unknow	4 Pregnant at time of dea	othe	r (Specify)				
	of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	Phy	Part II. Other significant conditions	5 Olikilowii	sulting in the unc	derlying cause given in	n Part I.	23e. Did tobacco	use contribute to	the cause of death?
	P.O. es that the igned by be detach	<u>ج</u>						1 Yes 2	No 3 ✔ Pro	bably 4 Unknown
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	e law te has ge 2 sl	m		· · · · · · · · · · · · · · · · · · ·				performed? 1 ✓ Yes 2 N	death?	
	II R	ျပ	25. Was case referred to medical			26.Place of De	ath (Check only			
	of Vital Records, ng Physician: The law requirements the this certificate has been someral director, page 2 should	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		Indianing inc		ence 6 🗸 Othe	r: Scene
	n of V ding Phy After t	ı.	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ury 28c. Injury at V		. Describe how in	jury occurred	
	Division tal or Attendin safter death al Director:  Alled in by the fu	Certification:	2 Accident Pending		ome farm street			Location (Street	and Number or R	ural Route Number, City
	Divi	ırtifi.	3 Suicide 6 Could no determin	ot be	me, raim, street,	actory, onice building	201.	or Town, State)		
	Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Pinneral Director: After this certificate has been signed by the attending physician and completely filled in by the fumeral director, page 2 should be detached for use as the burial - transi		29a. Certifier Certifying Physics	cian: To the best of my knowledge	ge, death occurre	ed at the time, date an	d place, and due	to the cause(s) a	nd manner as sta	ted.
	o the l ithin 2 o the l	Medical	one) 2 Medical Examin	er:On the basis of examination at and manner stated.	nd/or investigatio	n, in my opinion, deat	th occurred at the	time, date and pl	ace, and due to t	ne cause(s)
	F ≥ F 8	١١	29b. Signature and title of certifier			29 c. License num	nber	29d.	Date signed (Mo	onth, Day, Year)

Pameia E. Southall, MD State 31. Date filed (Month, Day, Year) istrar APR 28 2009 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 22, 2009

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mo

21r

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

333 MILLST. HAGERSTOWN, MD 21740

4/20

Katem Smoth CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** no middle name Jerwick Eugene 2009 10:07 A^M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14032 Poplar Grove Road Washington Hagerstown 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 058-36-7562 Mar 4, 82 Poland **Director** Usual Residence of Decedent 10d, Inside City Limits 10a State 10h County 10c City Town or Location ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination until be notified at NY Sea Cliff 1 Yes 2 No Director Nassau the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 156 DuBois Avenue 11579 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". or incorporate. 12. Was Decedent Ever in U.S. Armed Forcest? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 💆 No Specify white 2 Specify: 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electric machines engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irene Czerwinska Julian Jedrzejkiewicz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14032 Poplar Grove Road, Hagerstown MD 21742 John Jerwick son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Cumberland Valley 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Apr. 24, 2009 Waynesboro PA 17268 Crematorium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, PAn 17268 Doer pessa 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Grostate curcer metastatic disease or condition resulting in death) to /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transî Exami Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Ye ar 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 12 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only

1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier mykea Kuttner - Sando, mo

29d. Date signed (Month, Day, Year) 29c. License number

April 22, 2009 047451

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), County Cynthia Kuthner-Sands, MD Hospice of Washington 747 Northern Avenue

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

within 24

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			for State Registrar	State of Mar	yland / [		ment of h		d Mental Hy	giene Reg. No.	0000	13594		
			Registrar     Decedent's Name (First, Middle, La	st)					2. Date of D	eath		3. Time of Death		
	Physici			NIA MARIE KU	THN				Month APR	8 Day	2009 Year	8:32 P M		
MEZ.	/Medic Examir		4a. Facility Name (If not institution, giv			46	o. City, Town, o	r Location of De	ath		County of Death			
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П	Funeral		Social Security Number     6. S	'	In yrs. last bir	M	Under 1 Year onths Days	If Under 24 H Hours M		irth	9. Birth	nplace (State or Foreign		
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	w w		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Tow	n or Location	on				T	10d. Inside City Limits		
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	ms 2:	Jera	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was			(Specify Yes or N erto Rican, etc.)		14. Race - Amer	rican Indian,		
0	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2X No			s, specity Cuba Yes 2 <b>X</b> No		erto Hican, etc.)		Black, White Specify: Whi			
0-000-c	ral", c	l by	3	If Yes, Give Year or Dates:		''	res ZALINO	Specify:			Specify: WUI	. te		
ה	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	. Decedent (Give kind	's Usual Occup I of work done	oation during most of v d)	vorking	16b. Ki	ind of Business/I	ndustry		
7	ithin ne. han "	Ig II	Elementary/Secondary (0-12)	College (1-4or 5+)	٨٨			a) e Assist		Ret	ail			
7	led w lygie her ti		17. Father's Name (First, Middle, Last		Au	mini	CLOCIVE		lame (First, Middle					
_	~ = 0 =	a	Albert J. Banke						ne Becker		<i>Juliame</i>			
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2	d2s Ithar 7is trau		Patricia K. Crave			-				-		land 20901		
บ์	1 an Hea tem 2		20a. Method of Disposition	2 2008202			n (Name of ery or other place		Date	-	ocation - City or T			
<u> </u>	ages ant of tt: If It		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State					5/5/2	2000	Arlinata	on, Virgini		
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r.	that the ed by detac		Part II. Other significant conditions of	contributing to death but i	not resulting in	n the under	lying cause giv	ren in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?		
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Spics	v requ	Completed							24a. Wa	e an	24h Were au	topsy findings available		
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5	n: Th ificate or, pa		25. Was case referred to medical	-				00 50		2 XNo	1 □ Yes	2 🗆 No		
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5	al or s afte	Certification:	4 ☐ Homicide determined	building, etc.	(эреспу)				City or 10	wn, State				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit		29a. Certifier  1 X Certifying Pi (Check only)  2 Medical Exa	nysician: To the best of miner: On the basis of e	my knowledge	e, death oc	curred at the ti	me, date and pl	ace, and due to th	e cause(s	) and manner as	stated.		
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			30. Name and address of person who			(Type, Prin	t)					AL CENTER		
			CARL W. PETERS	CDR MC U	SNR			· E	BETHESDA	MD :	20889-56	000		

State Registrar 31. Date filed (Mbhfh), Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year Physician April 11, 8:20P. Margaret Mary Kerns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Nursing and Rehabilitation Center Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 1976 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 217-36-5214 1 □ M 2 1 F 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes X No Mərvlənd Montgomery Germantown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 20876 11010 Treva Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (9-12) Sales Clerk Retail Sales ges 1 and 2 should be filed to the filed to the file and Mental Hygis if item 27 is marked other to traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Boswell Irene Deutche 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elwood C. Kerns -Son 11010 Treva Court Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 4/15/2009 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donala do do Borgwardt Funeral Home, PA U ca 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be execute burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: Se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension; Atrial Fibrillation; Diabetes Mellitus 1 Tes 2 No 3 Probably 4 Nunknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【No , page 2 has autonsy perform 1∐ Yes 2 certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 은 this funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation Injury thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the within 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D28656 April 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 15225 Shady Grove Road, #208 Rockville, Maryland 20850 31. Date filed (Mohth, Day, Year) 32 Registrar's Signature State 14 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month **Physician** April 5, 12:15 PM William McKinley Keller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Bowie 12117 Mackell Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Oct. 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Massachusetts 88 015-12-2308 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination ust be notified at 1

Yes 2□No Director Prince George's Bowie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 12100 Faith Lane death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of the Elementary/Secondary (0-12) College (1-4or 5+) United States Navy d 2 should be filed with and Mental Hygier 7 Is marked other th 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph S. Keller ပ Florence Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any Injury or other traun 12100 Faith Lane Bowie, MD 20715 Irene Keller/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/7/2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Multinfarct Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the certified Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by t the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Assisted Living Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie J 4 405 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Andrew Dobin, M.D. 4175 N. Hanson Court #203A Bowie, MD 20716 31. Date filed (Month, Day, Year) APR 13 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O Z Year **Physician** 2009 12:00 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner in napolis Anne Arundel Medical Lenter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min Months 129M 2□ F landand N/AYrs 04/08/2009 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State show 1 ☐ Yes 2 No Directo isbur Wicomico Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 5 Pages 1 and 2 should be filed within 72 hours after death with States Krookridge United 405 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No 1 SNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ➡No Specify: Specify: White δ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/AN/A $\circ$ is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Hope Oxtord Alison ဂ acob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) Kinlaw Salisbury, Md 21x04 Brookridge Dr. Alison mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/2009 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, dromplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGENITAL ANOMALIES **Physician** /Medical Due to (or as a consequence of): 10 HRS Examiner TRISOMY 18 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖼 🕏 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) neral Director: After the filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 29b. Signature and title of certifier APRIL 8, 2009 D38075 en mo 30. Name and and ress of person who completed cause of death (Item 23a) (Type, Print) 2001 MEDICAL PARKWAY, ANNAPOLIS MD 21401 JAMI REYES 14MC 32. Registrar's Signatur State

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Registrar

			For State Registrar		State	of Mai	ryland		ırtmer <i>tificat</i>				lental I		ene . №Ω (	100	1 /	2500
	Physicia	n	Decedent's Name (Firs.)	, Middle	,	not	Tittle						2. Date o Month <b>April</b>	f Death	Day <b>1.0</b>	Year 2009		ne of Death 10:20p M
0	/Medic Examin		4a. Facility Name (If not in		give street and n		Little		4b. City,		Location		е			nty of Death		
	Funeral Director		5. Social Security Number 579-14-3912		6. Sex 1 ☐ M 2 🗷 F	7. Age	(In yrs. lasi	t birthday) Yrs.	If Unde Months		If Under Hours		8. Date o (Month <b>July</b>	f Birth n, Day, Y 25,	ear) <b>L921</b>	9. Birth	place (S intry)	ate or Foreign  Columbia
	death with the Maryland ims 23a or 28a-f show recent be notified at	tor	Usual Residence of Deceded 10a. State 10b.  Maryland	County	gomery		10c. City, 7	Town or Lo	cation	Che	evy Ch	ıase				de City Limits Yes 2 X No		
	with the a or 28a	Director	10e. Street and Number				10f. Zip Code						10g. Citizen of What Country?					
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evander in at be notified at once.	by Funeral	11. Marital Status  1 Never Married 2  3 🗷 Widowed 4 🗆 D	☐ Marri	12. Was De Armed F 1 Yes If Yes, G	Forces? 2 🔀 No Bive		1	Was Dece fYes, spe		2081.5 ispanic Oan, Mexica Specify	rigin? (Sp ın, Puerto	ecify Yes o Rican, etc.				in,	
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yland 2	ould be filed Mental Hyg arked other atic event,	To Be C	•										Rose	L. T	inker			
Mar	id 2 sho Ith and 27 is ma	33	19a. Informant's Name/R Alan K. Litt						•				al Route N  Chase			wn, State, Z 20815	ip Code)	
Baltimore,	Pages 1 ar nent of Hea nt: If item 2 iry or other		20a. Method of Dispositio  1 Burial 2 Cre  4 Donation 5 0	n mation	3 ☐ Removal from	n State	1	e of Disponetery, cren	sition (Na natory or	ne of ther plac	re)		Date 6/2009	20	c. Locatio	on - City or T	,	
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8760, 5	Physician and physician and physician and sthe burial-transit sthe burial-transit	al Examiner	23a. Part1. Enter the diss shock, or heart failu Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immedia cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last	re. List	a. For Due to Due to C.	ailure o (or as a ementi o (or as a	e to The consequer	nce of):	er the mo	de of dyir	ng, such a	s cardiac	or respirato	ory arres	t,			l Between and Death nth
O. Box 687	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent preging the past 12 month 1 □ Yes 2 ☑ No 9 □ Unknown			e birth 2 egnant at	of pregnanc 2 □ Fetal de time of dea	eath 3	Ectopic Other (s		у				23d.	Date of deli Month	very Day	Year
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MAR	he law re e has bee	Completed by	Anemia											Was an autopsy performe	ed?	prior to death?	ompletio	lings available n of cause of
${\mathcal E}$ , Vital	iclan: The law certificate has ector, page 2 a	Be C	Osteoar 25. Was case referred to examiner?		Hospital:					Oth	-	ce of Deat	1 □ Y		XINo	1 □ Yes	2 LIN	
4	To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending	28a. Dai	☐ Inpatier te of Injur onth, Day,	nt 2 ☐ EF y Year) 2	R/Outpatier 8b. Time of Injury		28c. Injur Worl	y at		ome 5   28d. Desc			Other (Spec	cify)	
L/f	tal or Atters after destal Directored in by the	Certifica	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could r determ	pod 28e. Pla	ce of Injui Iding, etc.	ry - At hom (Specify)	e, farm, str	eet, factor	y, office			28f. Locati City o	ion (Stre	et and Nu State)	umber or Ru	ral Route	Number,
	the Hospi nin 24 hou the Funer pletely fill	Medical	(Check only 2 one)	<i>le</i> dical	g Physician: To t Examiner: On the and ma	he best o basis of mer stat	examinatio	edge, deat n and/or in	vestigatio	n, in my o	opinion, de	eath occu	, and due t	time, dat	e and pla	ce, and due	to the ca	
	To t To t	Μ	29b. Signature and title o	f certifier	1	Sa	là	mi	<u>کو</u>		e number 010493			290		gned (Month pril 13		
				. Sai	a, M.D., F	ACP,	1201 S	even L		oad,	Suite	202,	Rockvi	11e,	Maryl	and 208	354	
	Sta Registr		31. Date filed Month, Da				r's Signatu		Kal									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month Hilda Elsie Laue Lawrence 12:12p M April 10, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) January 26, 1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 🗓 F 219-12-4787 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Silver Spring 1 ☐ Yes 2XXNo MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20904 3116 Gracefield Road Apt. T14 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electrical Company College (1-4or 5+) Elementary/Secondary (0-12) Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelmina Carolina Kreinhop Friedrich Johann Conrad Laue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14453 Jaystone Drive, Silver Spring, MD 20905 19a. Informant's Name/Relationship (Type. Print) Linda Lawrence / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cate of Heaven Cemetery April 15,2009 Silver Spring, MD of Funeral Service Licenses Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

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Director

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permit. Pages 1 and 2 st. Department of Health and Important: If item 27 is m any Injury or other traum

72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

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Examine law requires that the death certificate be executed and burial-trar physician a Physician/Medical attending pl the ģ 9 Completed page 2 should

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Director: d in by the f

ו 24 hours a Puneral I

within 2

filled in by after

death.

Hospital or Attending

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Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2XXNo

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 HInknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

24a Was an

1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown

autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2XXER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D67355

April 10, 2009

Daniel Sheth 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year) 14

32 Registrar's Signatu

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3601 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eugenie Marie Lafranchise 2009 1:15a M April 12, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice - Casey House Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours Min. 1 □ M 2 🛛 F 577-34-3091 80 DC July 1, 1928 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Silver Spring Montgomery 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3152 Gracefield Road, MS 403 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2XXNo White Specify: 3XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Religious Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Marie Martin Charles Phillip Merkle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Lafranchise, Jr. / Son 1611 Hunt Meadow Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State April 16, 2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 AnneMariewarne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal Cell Carcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 □ Yes 2**X** No 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Midical Examinations by notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Evar, in 2008.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the at be detached f certificate has been s rector, page 2 should director this funeral After

Examine Physician/Medical β Completed Be Certification: To after death Director; filled

24 hours a To the Hosp within 24 ho To the Fune completely f

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6XXOther (Specify) Hospice IFU Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2∏XNo 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XX Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Docelyne kouchthou, MJ 29c. License number 00063748 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou

201 East University Parkway, Baltimore, MD 21218

State Registrar

Medical

18. Mother's Name (First, Middle, Maiden Surname)

19711

20c. Location - City or Town, State

New Castle, DE

Wilm., DE 19803

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

unknown

Anna May Dawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

McCrery Funeral Home 3924 Concord Pike

2 E. Galloway Court, Newark, DE

Gracelawn Memorial Park 04/13/09

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 23a or 0, Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Inc. 2006. 1 - For State Registrar

10a, State

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 D9ther (Specify)

1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State

31. Date filed (Month, Day, Year) APR 15 2009

32. Registrar's Signature

Adolph Bock

Nancy Lane 20a. Method of Disposition

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Physici: /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deatt

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

she	rt1 Enter the disease, or com ock, or heart failure. List only	plications that c one cause on e	aused the deat ach line.		4		_			Approximate Interval Betwee Onset and Deat
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cause (I Cause (I that initia	ially list conditions, adding to find editate Enter Underlying Disease or injury sted events in death) Last	c	or as a conseq							
in ti 1 □	ALE: s decedent pregnant he past 12 months? JVes 2 No		oirth 2  Feta nant at time of	aldeath 3□Eo	topic pre				23d. Date of de Month	elivery Day Yea
Part II. O	ther significant conditions of	contributing to de	eath but not res	ulting in the under	lying cau	se given in Part I.		23e. Did tobacco		to the cause of death
							-	24a. Was an autopsy performed?	prior to death?	utopsy findings ava completion of caus
	case referred to medical			**		26. Place of De	eath (C			
	Yes 2 No	Hospital: 1 □ I	npatient 2	ER/Outpatient	B 🗆 DOA	Other: 4 Nursing	Home	5 Residence	6 ☐ Other (Sp.	ecify)
1 🖭	ner of Death Natural 5 Pending Accident investigation	,	of Injury th, Day, Year)	28b. Time of Injury	280 M	lnjury at Work? 1 □ Yes 2 □ No	28d	i. Describe how inju	ry occurred	
	Suicide 6  Could not b determined	28e. Place buildi	of Injury - At h	ome, farm, street,	factory, o	ffice	28f.	Location (Street a City or Town, Stat	nd Number or F e)	Rural Route Number,
		miner: On the b				the time, date and place my opinion, death occ				
Uli						icense number			ate signed (Mon	ith, Day, Year)
29b. Sign	e and address of person who									

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month, **Physician** emons lames /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimor OPKIN-Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2□ F 57 23 1951 Puerto Rico Director 462-98-0822 Dec. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c City, Town or Location 28a-f show The marked other than "natural", or items 23a or 28a-f shot traumatic event, I'm "section Experient must be notified." 1 ☐ Yes 2X No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21207 USA 1204 Brigadoon Trail Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify 2 Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Manager Airline 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h James Alvie Lemons, Sr. Carmen L. Collazo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. 19006 Rock Maple Drive, Hagerstown, Maryland 21740 James A. Lemons - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Hagerstown Crematory 4/15/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses Salut B. Rankin 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 20×14 disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) this certificate has been signed by the al director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**(No 1 ☐ Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 ☐ Accident 5 Pending investigation n 24 hours a er death. e Funeral Director. Aff eletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2. the

State Registrar

29b. Signature and title of certifier

Donald 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 North Wolfe St. Baltimore, Md, 21287

RES-000

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:40PM 1 1 2009 Ellen Leonard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown North West Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7/17/1951 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Couin MD 1 □ M 2 🔀 F 57 Director 220-56-9697 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Annapolis MD Anne Arundel 1 ☐ Yes XIX No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 21401 USA 3 Steele Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No White Specify Specify. δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygenist Denta1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F is marked of Edith Earle ပ Nathan Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 3 Steele Ave. Annapolis, MD 21401 Edith Earle Leonard Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o ty⊒Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/2009 4 Donation 5 Other (Specify) Kneseth Israel Cem Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Fud Renal **Physician** tuge 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☒ No Year Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

Pro1 12, 2009 29b. Signature and title of certifier DJ4053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Imith Ace Balt MD 2835 pplebaum Registrar's Signatur

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Registrar DHMH 17 Rev 1/2001

Crism. Shelcitka

32. Registrar's Signature Diene S. parks

Name and address of person who completed cause of death (Item 23a) (Type, Print)

VISM. Shelcitka, m. D. St. agnes Hospital - 900 Cator avenue. Baltimore, 252

ia Sharron Lord		State of Maryland / Department of Health and Menta - For State Certificate of Death Registrar	al Hygie		. No.	200	9   360
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Da	ate of Death onth I arch 28, 2	Day Y	ear	3. Time of Death 0434 hrs
Medical Examin		Kia Sharron Lord  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of		arch 28, 2		y of Death	
	Н	7100 Marlboro Pike District Heights				George'	
Funeral Director		5. Social Security Number 6. Sex 1. Months 2X F 24 1. Months Days Hours			/1985	(Y) 9. Birth Foreigr Cou	Maryland ntry
ny	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			·		10d. Inside City Limits
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once,	Director	10e. Street and Number		100	g. Citizen of N		try?
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 14. Whence Married 2. Married Forces? 15. Was Decedent of Hispanic Origin 16. Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, Mexican, If Yes, specify Cuban, If				ce - Americ nite, etc.	can Indian, Black,
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D 21 should and Me 7 is ma	유	19a. Informant's Name/Relationship (Type, Print )  Ron Lord/father  19b. Mailing Address (Street and Number 2956 Beaverwood)					
and 2 sho lealth and trem 27 is traumati	-	20a Method of Disposition 20h Place of Disposition (Name of cemetery.	Dat		20c. Locatio		
more Pages   ent of   nt: If	Į	1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Dooration 5 Other Specify:	4/9/	'09	Land	over	, MD
Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex	İ	21. Signatur of Furth Spice Censee 22. Name and Address of Facility BK Henry Fund		Chan			Street NE
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/Medical		failure. List only one cause on each line. U  Immediate Cause (Final disease a. Multiple Injuries					Between Onset and Death
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Vital ysician this cert	Be	examiner?  1 ✓ Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other	Nursing Ho		Residence	6 🗸 Othe	r: Scene
Division of Vital Records, la lor Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the contractions of the funeral director.	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work	Driv		now injury occ		
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Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due	to the caus	e(s) and mar	ner as sta	ied.
To the Ho within 24 F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.		e time, date			
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.			March 2		onth, Day, Year)
		30. Name and ddress of person who completed cause of death (Item 23a)		_			
8		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 212	201			
	ate	31. Date filed (North Pay Year) 2009 Registrar's Signature					
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Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner Certification: To within 24 hours after death. To the Funeral Director: A Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09 MDD66166 MA Karca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. 7th St. Frederick, Md. 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AFK 20 ZUUS Registrar **ORIGINAL** 

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygieneo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Elizabeth Marie Morrissey April 2009 8:17 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 102 E. Second Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🗓 F Yrs 02/04/1933 76 Maryland Director 214-28-6384 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, he "socies learning in it is notified at 1)∑Yes 2 No Director MD Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 102 E. Second Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No altimore, Maryland 21215-0036 Specify. Specify <u>م</u> 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Lena Charles ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11700 Upper Eastman Road, Cumberland, MD Tina M. Fear / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any Injury or o 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Cumberland Crematory 04/14/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Signature of Funeral Service Licensee Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** UDDER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ininterliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 4 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for the context. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 € 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou

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completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2009 D0054004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRS M.D., 1221 National Highway, LaVale, MD Shiv C. Khanna, 31. Date filed 32. Registrar's Signature State

Registrar

December Name   First Address, Laser   Firs				For State Registrar	State of Ma	aryland				lealth and N Death		giene Reg. No.	2009	13609
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Physician Medical Examiner    Physician Medical Examiner   Physician Medical Examiner   Physician   Ph			. I	shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,		Interval Between
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Physician		tegistrar 1. Decedent's Name (First, Midd	lle,Last)	-						2.	Date of Dea		Year	3. Time of	Death
Medical Examine		Giovanni				rangel	O 4b. City, To	um orl	section of		April 17,	2009	County of Dea	1538	nrs
1		4a. Facility Name (if not instituti Black Valley Road	on, give stree	t and number	7)		Flintso		ocation of	Death			llegany		
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. las	st birthday)	If Unde		If Under	1.00	8. Date of B		Fore	irthplace (Sta	ate or
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any	F	Usual Residence of Decedent  10a. State 10b. County			10c. City,	Town or Locati	ion							10d. Insid	le City Limits
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death with the Maryland or items 23a or 28a-f show must be notified at once.			Creek			Tion	<u> </u>	215		-0./ 5	if. Vac or N		USA 14. Race - Ame	orican Indian	Black
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Pages nent of ant: I	- [	1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 04/20/2009 Cumberla Cumberland Crematory 04/20/2009 Cumberla										-			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21 Signature of Funeral Service Licensee  22. Name and Address of Facility Adams Family Funeral H 404 Decatur Street, Cumberland, MD													
Physician	$\dashv$	23a. Part J. Enter the disease,	or complication	ns that cause	ed the death.									Approxi	imate Interval
Medical		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):													Death
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	<u>آ</u> و	Sequentially list conditions, if any, leading to immediate		o (or as a cor	sequence of	f):									
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1 of Vital Records, P. ling Physician: The law requires th After this certificate has been signe funeral director, page 2 should be de	٦: T	1 Yes 2 No 27. Manner of Death		28a. Date of I	njury	28b. Time of			ry at Work				jury occurred		to avoid fire
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To the Hos within 24 h To the Fm	Medical	(Check only one) 2 ✓ Medical Ex	kaminer:On t	he basis of e manner state	xamination a	nd/or investig	ation, in m	y opinion	, death oc	curred at	the time, da	ate and p	lace, and due t	o the cause(s	
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11,63		<ol> <li>Name and address of pers Donna M. Vincenti, I</li> </ol>		istant Med			1 Penn	Street	Baltim	ore, MI	21201				
Sta	ate	31. Date filed (Month Day, Yea	nna /	32. Regis	trar's Signati	ure All					-				
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #18, 1- State Registrar TCHD, 04/13/2009, TLS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** 6:58 AM MARY VERNON MULDER April 11 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Genesis HealthCare -The Pines 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2 XX 216-12-1973 86 Director JULY 11. 1922 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show XXYes 2 No Exeminer must be notified EASTON Directo TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö USA 23a 21601 610 DUTCHMANS LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX

If Yes, Give
Year or Dates: Black, White, etc. s 1 and 2 should be filed within 72 hours after of Heatth and Mental Hygiene. item 27 is marked other than "natural", or iter 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 XXIO Specify: WHITE þ 3 XXVidowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PUBLISHING BINDERY WORKER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mulder FLORENCE-LECOPHTE- LECOMPTE CHARLES HAMBLETON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27564 ST. MICHAELS RD. EASTON, MD 21601 BONNIE L. SHORTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or oti tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEM PARK 4-16-2009 EASTON, MD 22. Name and Address of Facility 21. Signature of Edneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Estrowski Joseph 200 S. HARRISON ST. EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner phera Sequentially list conditions, if any, leading to inimiculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed menta to (or as a consequence of): physician a the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 □Yes 2 □ No Director: d in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TLS

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

APR 13 2009

ROWLEY 610

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Mai	yıand	•	ent of He ate of D		i wentai H		.2009	13612
	Physici		JAMES H.		st)					2. Date of I	_	ay Year	3. Time of Death
0	/Medic Examin Funeral Director		4a. Facility Name (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	umber 6. S		EAS (In yrs. las	ton.	East ider 1 Year	OCATION of Dea	's. 8. Date of I	Birth Day, Year	9. Bir	thplace (State or Foreign ountry)
			Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town or Location						10d. Inside City Limits
	Maryla -f sho	tor	MD	TALBOT			GHMAN						1 ⊡Yes 2XXXNo
	or 28a	Director	10e. Street and Nur					Zip Code			10g. C	itizen of What Co	puntry?
	ath wi		21308 PH	ILLIPS RI	Y		1,5,111, 5	2167		(O'/ V	1	USA	otaan Indian
(5) 15-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Mydical Exacultar inset to codiffic d at	by Funeral	11. Marital Status  Never Marri  Widowed	ed 2 Married	12. Was Decedent Ev Armed Forces? 1 □ Yes ATT No If Yes, Give Year or Dates:			specify Cuban	panic Origin? , Mexican, Pue Specify:	(Specify Yes or erro Rican, etc.)	VO-	14. Race - Ame Black, White Specify: WI	
<u> </u>	vithin 72 ho sne. than "natur e Medical	etec	(Spec	15. Decedent's Ed	ducation de completed)		16a. Decedent's U		tion uring most of w	orking	16b.	Kind of Business	/Industry
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Le,	iges 1 and 2 nt of Health : If item 27 i or other tra		20a. Method of Disp	position		20b. Pla	ace of Disposition (			Date		Location - City or	Town, State
<u>₹</u>	Page ment c ant: If ury or		1	□ Cremation 3 □ 5 □ Other <i>(Specit</i>	Removal from State	1	GHMAN MEN			-17-2009	TI	LGHMAN,	MD
Baltimore, Maryland 21	permit. Pages 1 Department of P Important: If ite any Injury or of once.		21. Signature of Fu	m. Os	tiesuski C.1		200_9	. HARR	LISON S	T. EAS	ON,	FUNERAL MD 2160	HOME, P.A.
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Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 Unknown	months?	23c. If yes, outcome o  1  Live birth 2  4  Pregnant at 1 9  Unknown	Fetal	death 3 Ector	oic pregnancy r (specify)			-	23d. Date of de Month	elivery Day Year
ο, σ,	is that t gned by e detac	by Ph	Part II. Other signi	ficant conditions	contributing to death but	not result	ting in the underlyi	ng cause give	n in Part I.	23e. D	d tobacco		o the cause of death?
ord	equire een siç ould b									- 1	□ Yes	2 □ No 3.□ P	robably 4 🗆 Unknown
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Vit	siclan s certif irector	Be C	25. Was case referexaminer?		Hospital:	+ 2□=	ER/Outpatient 3 □	0.1		eath (Check on		6 □Other (Spe	noifu)
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_	n 24 hours n 24 hours se Funeral	Medical C	29a. Certifier (Check only one)	1 ← Certifying P 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examinati-	rledge, death occu on and/or investiga	rred at the tim ation, in my op	e, date and plainion, death o	ace, and due to courred at the tin	the cause ne, date a	e(s) and manner a and place, and du	as stated. e to the cause(s)
	To the within Comp	Ň	29b. Signature and	title of certifier	V MD		23a) (Type, Print)	29c. License	number 66 4 La	1	29d. [	Date signed (Mon	th, Day, Year)
	TLS		30. Name and add	ress of person who	completed cause of de	ath (Item :	23a) (Type, Print)	^	- 17		F '-		
_	2		Kolli	Rainer	v 2195	was	Lungton	Sirece	E Ea	ston o	NO	21601	
	Sta	ite	31. Date filed (Mon	oth, Day, Year)	32, negistra	rs Signatu	A arke	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** THEODORE AUGUSTUS MOORE 2009 0910 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS **OUEEN ANNE'S** CENTREVILLE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1**X**X/1 2□ F 80 220-22-6259 Director JULY 27, 1928 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "hatural", or items 23a or 28a-f show nnt: If item 27 is marked other than "hatural", or other traumatic event, fre Modical Examiner must be notified at any or other traumatic event, fre Modical Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 □Yes XXNo MD TALBOT **Funeral Director** WYE MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13360 OLD WYE MILLS RD. 21679 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★★es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 KXIo Specify: WHITE Specify: Completed by 3 XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE CHURCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THEODORE A. MOORE ALVERTA KOENIG ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA WASILEWSKI DAUGHTER 13360 OLD WYE MILLS RD. WYE MILLS, MD 21679 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or o 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4-15-2009 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Monitobstruct disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 ☐ Yes 2 ☐ No or Attending Physician; funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TUS death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DYYA

3altimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

32. Registrar's Signature

21601 -- Michael D. Crowley, M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar #20a, 20b, FH, TCHD, 4/9/09, rlk Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ETHEL ELIZABETH MILLARD APRIL 2009 3:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON talbot Hospice House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Months Days 86 Director DC 579-22-8278 DEC. 18. 1922 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28a-f show traumatic event, the Medical Exeminer must be notified at **XX**Yes 2 □ No Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a 501 DUTCHMAN'S LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes XXNo
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married 1 □Yes XX No altimore, Maryland 21215-0036 ō Specify: þ ₩Widowed 4 Divorced WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 73 th and Menta! Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTHCARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAURICE L. BREWTON ၉ HELEN A. MITCHELL Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i MICHAEL K. MILLARD-SON 11601 KINGSWOOD BLVD. FREDERICKSBURG, VA 22408 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Chesapeake Cremation
ARLINGTON NAT'I CFM.

Date

20c. Location - City or Town, State
Stevensyille MD
ARLINGTON, VA 20a Method of Disposition Department of h Important: If ite any Injury or ot once. t Lorial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERCERON MOHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician re bur Jasc Jays disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 No certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes Division of Vital Records, P.O. a∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 💆 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6XXOther (SpecifyHOSPICE HOUSE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 | Pending s after death.

I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital
within 24 hours a
To the Funeral C
completely filled Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of ce 29c. License number 29d, Date signed (Month, Day, Year) 2009

Registrar
DHMH 17 Rev 1/2001

State

OPY

Back

555 Cynwood Dr.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signáture

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31. Date filed (Month

APR 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 3615 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lois Janet Massey **Physician** Year 0949 2009 /Medical tori 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Podle he Mamarial Hospita If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 4 2 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 □ M 2 KF 216-64-8341 67 Yrs. Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shov MD Queen Annes Sudlersville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Foxxtown Drive Apt. 21668 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items; any Injury or other traumatic event, this Medical Expression. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 0 College (1-4or 5+) Line Worker Campbell Soup 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Randolph Fletcher Ada Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24080 E. Cherry Ln. Goldsborough, MD 21636 Aleta Groce/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 04-13-09 Mt. Marydel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral home 426 Dover Road, Easton, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTISUSTEM MAN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. been signed by the same should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 2. No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 124 hours after death.
 Euneral Director: A letely filled in by the full 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month Park)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Stitely 505 B Dutchman's Ln, Easton, MD 21601 32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	-	•	ificate of		u Menta		Reg. No.	2009	13616
	Physicia	n	1. Decedent's Name (First, Middle, Las	st)					Mo	te of Dea	Dav	2009 ^{Year}	3. Time of Death
	/Medic		Robert Eugene Mon				. O. T.	- L No - of Do	Apr	il	09,	2009 County of Death	5:12 A M
	Examin	er	4a. Facility Name (If not institution, given 90 Waverly Drive,			4	b. City, Town, o Fred	erick	saur		40.	Freder	
Ī	Funeral Director		5. Social Security Number 6. S		(In yrs. last birt		If Under 1 Year Months Days	If Under 24 F	Hrs. 8. Da Min. (M Mar	te of Birl onth, Da ch 1	th Year) 7, 19	9. Birth Con Mar	nplace (State or Foreign untry) yland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Local	tion						10d. Inside City Limits
	Maryl	to	Maryland Frederi	ck		Fred	erick						1⊠Yes 2 No
	h the	Directo	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Cou	untry?
	ath wit		90 Waverly Drive,				2170					nited S	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evanities must be notified at once.	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:			as Decedent of H es, specify Cub Yes 2X No		? (Specify Yeureto Rican,	etc.)		14. Race - Amer Black, White Specify: B1a	, etc.
Baltimore, Maryland 21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-		Deceder (Give kir life. DO	nt's Usual Occup nd of work done NOT use retire	oation during most of a d)	working		16b. Kir	nd of Business/I	ndustry
2	ed with ygiene ier the	Com	12			Dis	patcher						overnment
and	be file	Be	17. Father's Name (First, Middle, Last) Thomas Tucker Mon					18. Mother's N					
٦	should nd Mei marke	၉	19a. Informant's Name/Relationship (		19b	. Mailing	Address (Street					r Town, State, Z	(ip Code)
Z	nd 2 s alth ar 27 ls r trau		John Monroe / Bro									MD 2170	
ore,	es 1 a of Hez r othe		20a. Method of Disposition	D	20b. Place of	Disposit	ion (Name of tory or other pla	ce) Api	ril 15	,	20c. Lo	cation - City or	Town, State
Ē	Page ment ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Memor	ial (	Gardens	1	200	9	Fred	lerick,	Maryland
Balt	permit. Depart Import any Inj once.		21. Signature of Fone Service Cer	see		Res	Name and Address thaven 1 Catoc	Funeral	Serv . Hwy	ices . Fr	, Sk eder	kot Cod ick, MD	у Р.А. 21701
			23a. Part 1 Enter the disease, or comshock, or heart failure. Lively	plications that caused one cause on each lin	the death. Do i	not enter	the mode of dyi	ng, such as car	diac or resp	iratory a	rrest,		Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Diabetes									Offiser and Death
2	/Medical Examiner		resulting in death)	•	a consequence	of):							
		Je.	Sequentially list conditions, if any, leading to immediate cause. Classes or injury	b. Hyperten Due to (or as a	a consequence	of):							
	cuted nd ransit	Examiner		c. High Cho									
90,	ificate be executed g physician and as the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence	of):							
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P.O. Box (	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death. The Sunest let death. The Funest Director: After this certificate has been signed by the attending propletely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnand Other (specify) _	су			2	23d. Date of del Month	ivery Day Year
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rds	quires en sigr uld be	ed by							_	1 🗆	Yes 2[	□ No 3□ Pr	obably 4 🙀 Unknown
Division of Vital Records,	Physician: The law requir r this certificate has been si ral director, page 2 should I	Completed						-	_	4a. Was auto perfo □Yes		prior to death?	topsy findings available completion of cause of 2 ☐ No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			_   01	26. Place of					
of	Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2XXNo  27. Manner of Death	28a. Date of Inju		Time of	28c. Inju	iry at				6 ☐ Other (Spe y occurred	cify)
on	th. : Afte	tion	1 ☑ Natural 5 ☐ Pending investigatio	(Month, Day	i, Year)	njury	Wo	rkí? ]Yes 2 □ No					
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		iry - At home, fa c. (Specify)	rm, stree	et, factory, office		28f. Lc	ocation ( ity or To	Street an wn, State	d Number or Ru )	ıral Route Number,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier 1 ★ Certifying P  (Check only one)	nysiclan: To the best of miner: On the basis of and manner sta	examination ar	e, death ond/or inve	occurred at the testigation, in my	time, date and p opinion, death o	place, and d occurred at	ue to the	cause(s , date and	) and manner as d place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Dat	te signed (Mont	h, Day, Year)
			1				00	11153	55			4/14/0	75
	5		30. Name and address of person who	completed cause of d	eath (Item 23a)			umtown 1	Pike,	Fre	deri	ck, MD	21702
Н	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature R 1 4 20				_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11:30P.14 Lorraine APRIL 2009 Mary Myers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Reeders Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 💢 F 217-20-0966 Director 81 May 10, 1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10h. County ıral", or items 23a or 28a-f show Examiner must be notifled at 1 XYes 2 ☐ No Directo Williamsport MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 303 S. Conococheague St. U.S.A. Funeral d 2 should be filed within 72 hours after death it and Mental Hyglene. 23 Is marked other than "natural", or items 23 traumatic event, the Medical Examiner musit traumatic event, the Medical Examiner musit 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Burger Belle (Burger) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other trat Marshall T. Myers/Husband 303 S. Conococheague St. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/16/2009 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee Þ 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ---**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner baltace Sale ein 3 4 Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ etituctit Pula 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Alphinein Dercen Drown Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00018019 (2-LT MC)

WH-3

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100

31. Date filed (Month, Day, Year)

APR 15 2009



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month NILLER Y NN 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1421 HARMONY LANE ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JANUARY 29, 1947 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 M 2 □ F Hours 62 CALIFORNIA 568-60-1853 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No ANNE ARUNDEL ANNAPOLIS MARYLAND 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 1421 HARMONY LANE 21409 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces? XYes 2 □ No 1966-Black, White, etc. 1**X**Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. Specify: WHITE 3 Widowed 4 Divorced 1990 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) FEDERAL LAW College (1-4or 5+) Elementary/Secondary (0-12) ENFORCEMENT 4 SPECIAL_AGENT 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) BERT ALFRED MILLER KATHERINE WHISNAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 HARMONY LANE, ANNAPOLIS, MARYLAND 21409 PAMELA BEAUDETTE MILLER/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEAKE CREMATION 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 2009 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CENTER 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee While Expose M00672 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final WIDELY TASTATIC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗆 Yes 2 🗆 No

Examiner Box 68760, o ₫. of Vital Records. Division

Examine certificate be executed and burial-trar attending physician Physician/Medical the as use or signed by the a ≥ page 2 should Completed peen Be ပ funeral Certification: al or Attending F s after death. I Director: After d in by the funera After filled in by

**Physician** 

/Medical

**Examiner** 

Funeral

Director

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Completed

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permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

/Medical

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Date signed (Month, Day, Year)

To the Hospital of within 24 hours a To the Funeral D completely

Registrar

Medical

NEL 31. Date filed (Month, Day, Year)

Signature and title of certifier

(Check only one)

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Name and address of person who completed cause of death (Item 23a) (Type, Print)



4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 11/15/1930 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1□ M 22 F Months 78 519-32-8256 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Eventual must be retified at sonce. Director MD Anne Arundel Arnold 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 USA 736 Carlisle Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Reid Lucille Garrison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregg Moore Son 736 Carlisle Drive Arnold,MD 21012 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Atlantic Crematory 4/13/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funetal Service Licens 12 Ridgely Ave al Hardesty Funeral Home P.A. Annapolis,MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence 8f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MOURE

1. Decedent's Name (First, Middle, Last)

ORIS

**Physician** 

/Medical

23e. Did tobacco use contribute to the cause of death?

Month

23d. Date of delivery

Reg. No.

Year 09

14. Race - American Indian, Black, White, etc.

Own Home

Specify:

White

M VS

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Approximate Interval Between Onset and Death

Boise, Idaho

2. Date of Death

Month 0 4

Yes 2 No 3 Probably 4 Unknown 24a. Was an

performed? 1 ☐Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

Day

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

28c. Injury at Work? 28d. Describe how injury occurred

Date of Injury (Month, Day, Year) 28b. Time of Injury 1 ☐Yes 2 ☐No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

VASCULAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 □ Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Latent A M 447 DEXENSE H & HWAY 30. Name and address of person Date filed (Month, Day, Year) 32 Registrar's Signature

Hospital:

1 Inpatient

Registrar

Certification: To

DHMH 17 Rev 1/2001

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records,

Be Completed by

within 24 hours after death To the Funeral Director:

		1 - For State Registrar	State of Marylan	-	artment of Hertificate of L		Reg	ene 0 (	09 13	8620
Physic	cian	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death Month	Day	Vear	e of Death
, /Mec		Anita G. Martone					April 1			0 P M
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or	Chase		4c. County	tgomery	
		Manor Care at Che 5. Social Security Number 6. Se		last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,		9. Birthplace (Sta Country)	ate or Foreign
Funera Directo			□M 2⊠F 87	Yrs.	Months Days	Hours Min.	May 1, 1	921 ]	Pennsylva	ınia
Maryland e-f ahow	ctor	10a. State 10b. County  Maryland Montgome	01	y, Town or Lo evy Ch						e City Limits Yes 2 No
with the	Dire	10e. Street and Number 8700 Jones Mill R	load		10f. Zip Code	20815	109	g. Citizen of W USA	Vhat Country?	
is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked othar than "natural", or Itema 23a or 28e-f ahow other traumatic avant, the Medical Examiner must be collided at	by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of Hi If Yes, specify Cubar		pecify Yes or No- pacify Yes or No- pacifican, etc.)	14. Race	e - American Indian k, White, etc. : White	٦,
of 2 should be filed within 72 hours at the and Mental Hygiene. It is marked other than "naturel", or traumatic event, the Medical Exempter	Completed b	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	Year or Dates: ucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	ition luring most of work )	king		siness/Industry	
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nat yiailu 2 should be file and Mental Hy 7 te markad oth raumatic avant	To Be (	17. Father's Name (First, Middle, Last) Paul Giorno					a Parise	aiden Sumam	θ)	
and 2 sho ealth and ! n 27 le ma		19a. Informant's Name/Relationship (7 Laura Slaugh / Ni			ng Address <i>(Str</i> eet a					
permit. Pages 1 an Department of Heal Importent: If Itam 2 any injury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State St	Place of Disponentery, creations Jose tholic	osition (Name of matory or other place ph's New Cemetery	4/16			City or Town, State Pennsylvan	
permit. Departm Importe any inju		21. Signatore of Funeral Service Licen		2 11 2	2. Name and Addres	s of Facility	me, P.A.	4739 Ba Hyatts	altimore ville, M	Avenue 20781
Physicial Ale De executed (Medica Examine Physician and Physician and Physician Ale Durial-translit	Examiner	23a. Part I. Enter the disease, or compensor, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a c	uence of):	Deme v	1	or respiratory arres	it,		Imate Between and Death
Attanding Physician: The law requires that the death certificate be redeath.  ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	by Physiclan/Medical		d.  23c. If yes, outcome of pregn.  1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mo	te of delivery nth Day	Year
uires that signed b			ontributing to death but not res	sulting in the u	inderlying cause give	en in Part I.			ribute to the cause	of death?
of Attanding Physician: The law requires I after death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	Completed						24a. Was an autopsy perform	ed?	Were autopsy finds prior to completion death? I  Yes	of cause of
ician: Sertific Sector,	e	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only one			
ing Phys After this o	lon: To		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c Injury World	4 Nursing H	ome 5 Resider 28d. Describe how			
= 5 ± 5 =	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, larm, st		103 2	281. Location (Str. City or Town,		er or Rural Route	Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical C		ysician: To the best of my known inner: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the tin	ne, date and place pinion, death occu	n, and due to the car arred at the time, da	use(s) and ma te and place,	anner as stated. and due to the cau	1SO(S)
	Me	29b. Signature and title of certifier			29c. Licens	e number 5 4 5 6		d. Date signe	d (Month, Day, Ye	ar)
33	State	30. Name and address of person who Sunitha Bho (31. Date filed (Month, Day, Year)		m 23a) (Type 1 Geo atus	Print)	hw #1	-17,538	versp	ring, pr	152091
Regi		.APR 15 2009 A.	wa D. Ja	Plan						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MEIER Month: **Physician** FRT 4/1 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 610 Yearling Ct. Severn Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Towa If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1921-14 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min 481-54-7012 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventure. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Anne Arundel Severn 1 ☐ Yes 🎗 🕅 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 610 Yearling Ct. 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1962-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 25 Married 2 🗌 No 1966 1 □Yes 2√No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Computer Analyst</u> <u>Department of Defense</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irwin Meier Mayme Barenthin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Yearling Ct. Laverne Meier Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sydenstricker UM Cem 4/15/2009 Springfield, VA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disea 4, or complications that caused 1 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final illen disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 🗍 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

Be

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and titlenof certifier

Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this within 24 hours after death To the Funeral Director: filled in by the completely

Medical State Registrar

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d Date signed (Month, Day, Year,

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPULI MALIYOU

32. Registrar's

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Apr 11, 2009 Camela Natale 1857 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS--Braddock Campus Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Ye Mar 23, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 W 236-36-1865 83 MD **Director** Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the "tedical Examiner must be notified at WV Mineral Ridgeley Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Mineral Street 26753 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the "section Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No If Yes, Give Year or Dates: Š Specify. Specify: 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Bennett Arline Tysinger ပ 19a. Informant's Name/Relationship (Type. Print)
Angela Feldstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21 Richard Way LaVale MD 21502 daughtei 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/14/2009 Cumberland MD 21. Signature of un ral Serv e Licens 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease shock, or heart failure. L Immediate Ca. e (Final disease or condition resulting in death) e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cape on each line. Approximate Interval Between Onset and Death **Physician** /Medical Live to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check or 2 ☐ Medical Exam per: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name

31. Date filed (Month, Day,

ddress of person who

APR 15 2009

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nRA

DHMH 17 Rev 1/2001

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0030 M Apri MARLYN IRENE NICHOLS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Easton al at 00 Months Days Hours Min. JULY 2, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Country) 1 □ M 2 XF Yrs. 61 222-30-5193 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No EASTON TALBOT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 33196 FOX RD. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL CASHIER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLYDE DALE TENNANT HELEN MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 33196 FOX RD. EASTON, MD 21601 RAYMOND E. NICHOLS - HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State CHESAPEAKE CREMATION: 4-8-2009 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERCE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 2069 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed; death? 1 □ Yes 2 □ No Gastroesophecen 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Phours after death.

Funeral Director: After this certificate has been signed by the attending physician and

thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and in the Funeral Director, page 2 should be detached for use as the burial-transit majoritely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

s 23a or 28a-f show ust be notified at

d other than "natural", or items event, the Medical Examination

is marked other

Department of Health Important: If item 27 any Injury or other to once.

**Physician** 

/Medical

Examiner

Pages 1 and 2 should be in nent of Health and Mental

Director

Funeral

Completed by

Be

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death with the Maryland

filed within 72 hours after

215-0036

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Maryland

Baltimore,

within 24 hours a
To the Funeral of completely filled

1 Natural 5 ☐ Per 2 ☐ Accident inv	nding (Month, Ďay, Year) estigation	Injury M	Work? 1 □ Yes 2 □ No		,
	uld not be ermined 28e. Place of Injury - At building, etc. (Spe	home, farm, street, facto	ry, office	28f. Location (Str City or Town	reet and Number or Rural Route Number , State)
	ifying Physician: To the best of my k cal Examiner: On the basis of exami and manner stated.				ause(s) and manner as stated. ate and place, and due to the cause(s)
29b. Signature and title of cer	half fra	ther	9c. License number	15 P	Od. Date signed (Month, Day, Year)
30. Name and address of per	son who completed cause of death (It	em 23a) (Type, Print) Vá Slungton	Street, Eas	bu MD Z	1601
31. Date filed (Month, Day, Ye	9 2009 32. Registrar's Sig	M. Aux			

DHMH 17 Rev 1/2001

Registrar

4b. City, Town, or Location of Death

EASTON

Month

APRIL

Day

2009

4c. County of Death

TALBOT

1130 A

**Physician** /Medical Examiner 1 - For State Registrar

HAZEL RUTH OXEE

WILLIAM HILL GARDENS

4a. Facility Name (If not institution, give street and number)

**Funeral** 

altimore,

P.O. Box 68760,

Division of Vital Records,

8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Min. Months Days Hours 1 M 2XXF 86 JULY 9, 136-20-3870 MD 1922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ms 23a or 28a-f show must be notified at 1 **X** € 2 □ No Director EASTON MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA 545 CYNWOOD DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d other than "natural", or items event, the Medical Examiner ma 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 🗶 😿 Specify ģ Specify: 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELEMENTARY EDUCATION TEACHER ulth and Mental Hygiel 27 Is marked other the traumatic event, Ins. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAZEL EVANS JOSEPH H. YATER ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 727 ELWOOD AVE. EASTON, MD 21601 SALLIE YATER - SISTER Department of Health Important: If item 27 any injury or other trong once. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 Cremation 3 Removal from State WOODLAWN MEM PARK 4-9-2009 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST. EASTON, MD 21601 HOME, P.A. MERLERO 4042 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mount /Medical a consequence of): Due to (or as Examiner e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or AttendIng Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cade given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy his certificate h I director, page un 1 ☐ Yes 2 No 2 7 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other repetity never 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death,

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Mannur of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 \ atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 RK 2140 Wood 31. Date filed (Month, Day, Year) State APR 0 9 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Bryan Month **Physician** 1950 PM April 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Social Security Number Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours UNK 44 **Director** Oct.4,1964 Marvland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location show 10a. State 10b. County must be notified at MD Director Montgomery Poolesville 1 XYes 2 No 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 19860 Beatrice Avenue 20837 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours after 1X Never Married 2 Married ō 1 Yes 2 No If Yes, Give Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: 'naturai", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Painter 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be and Mental Fisher is marked of John James Pierce, II Anna Mae Durham ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Snyder (Sister) 20116 Club Hill Dr, Germantown, MD 20874 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
important: If ite
any injury or of
once. 1 Burial 2 Cremation 3 Removal from State Ardent Crematory 4 Donation 5 Other (Specify) 4/10/09 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hypoglicema ou to (vas consequence of) 6 hours disease or condition resulting in death) /Medical **Examiner** 48 hours Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed 2 weeks acute renal physician and as the burial-trans Physician/Medical year renal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ed by the att detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alcohol 1 Yes 2 No 3 Probably 4 Unknown pancrealitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No coaquiopathy 2 - No 25. Was se referr to medic examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 5 \subseteq Residence 1 ☐ Yes 2 ☑ No 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury ir death. irector: / 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760, P.O. Division of Vital Records,

altimore, Maryland 21215-0036

or A 24 hours within 2 To the #

> MARC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

29a. Certifier

29b. Signature and title of certifier

Medical

who completed cause of death (Item 23a) (Type, Print)

2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES

 $\alpha 0$ 

29d. Date signed (Month, Day, Year)

April 7 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 12:45 AM Helen L. Pettie 2009 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, Year) Dec. 23, 1950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Min. Hours Maryland 1 □ M 2 👽 F 58 217-56-3237 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event and its beneated any injury or other traumatic event, the Medical Event and its beneated. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Baltimore City Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 United States 3217 Kenvon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married White 1 □Yes 2X No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Evelyn Franklin Robert H. Miller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3217 Kenyon Avenue Baltimore, Maryland 21213 Lerov Pettie -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4/10/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Stage over 1 year **Physician** 14 monary disease or condition resulting in death) /Medical Due to (or as a co equence of): arcinoma with lobectoming Examiner Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ~ monary and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy 2 No certificate 2 1 No 1 Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

within 2 the 2 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wicson, MD UNION MEMORIAL MOSPITAL, 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 14

29a. Certifier

29b. Signature and title of certifier

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Dav Year **Physician** CHARLES CARROLL PARKER APRIL 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. Director 218-16-6533 83 May 10, 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic exercises. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Whittier Drive Funeral 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No 2 Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Charles Smith Parker Norma O. Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Parker, son 305 Bolivar Drive, Yorktown, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Montgomery Methodist Cemetery Damascus, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part, intir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final dise se or condition result in a in dee th) Onset and Death **Physician** - andromy /Medical Due to (or as a consequence ) Examiner sobable Sequentially list conditions, if any, leading to immediate cause. Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

Neral Director: A
filled in by the fu death. 1 ☐ Yes 2∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) shah Hemen · C Thomas 65 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

APR

1 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Raymond Milton Palmer /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 13, 1931 9. Birthplace (State or Foreign 6. Sex 1**XX**M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days 220-28-3091 Director 77 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examination to difficult and the confiled at once. Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 17000 Hillsdale Ct. USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1XXes 2 ☐ No If Yes, Give Year or Dates: 1953-1 Never Married 2 Married Maryland 21215-0036 Specify 3 Widowed WDivorced 1974 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Military Supervisor 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ္ Otho Milton Palmer Dorothy L. Bowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wilson - Sister 122 Paul's Place Falling Waters, West Virginia 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation Greenlawn Mem. Park Apr.18,2009 Williamsport, Maryland 4 ☐ Domation | 5 ☐ Other (Spe Oshorned Hunerally Home, P.A. 21. Signature of Funeral Se 425 S. Conococheague St.Williamsport, MD 21795 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a) or sequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transi resulting in death) Last Due to for as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ rem 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 🗌 No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only onle) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

30. Name and address of person who

41 DIEC

mpleted cause of death (Item 23a) (Type, Print)

2053 gistrar's Signature

	1	For State Registrar		,	partment of Hea Certificate of Dea		F	Reg. No.2	13629
sician edical	•	Janet	Leigh Pa	arker			2. Date of Dea Month April	10, 2009 Yea	1319 hrs M
miner	4	a. Facility Name (If not institution, gr Shady Grove Adv	entist Hos	spital	4b. City, Town, or Loca  Rockville	e		4c. County of De	omery
ral tor		225-87-8684	Sex 7. A 1 ☐ M 2 <b>X</b> F	73 Yrs.	Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birtl (Month, Day December	h, Year)1935 ^{9. B} (er 28, Sie	irthplace (State or Foreign Collifest Africa erra Leone,
tor	1	Jsual Residence of Decedent  Oa. State 10b. County  Maryland Montgo	merv	10c. City, Town o	r Location hersburg				10d. Inside City Limits 1 X Yes 2 □ No
Director	1	0e. Street and Number			10f. Zip Code 20879			10g. Citizen of What C	-
any injury or other traumatic event, tree peace. Examine measure and once.  To Be Completed by Funeral Director	2	7413 Brenish Dr  1. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Forces	No No	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 □Yes 2 N No Sp			- 14. Race - Ar Black, Wh	nerican Indian,
Completed	- Indicate	15. Decedent's Elementary/Secondary (0-12) 12th grade	Education rade completed) College (1-4o		ecedent's Usual Occupation Give kind of work done during fe. DO NOT use retired) <b>Housewife</b>	n g most of workii	ng	16b. Kind of Busines	ŕ
To Be Co	3 1	17. Father's Name (First, Middle, Las Samuel Leigh			18.	Mother's Name August		Maiden Surname) 1	
er trauma		19a. Informant's Name/Relationship Felicia Quentin-	•	741	ailing Address (Street and I 3 Brenish Dr isposition (Name of crematory or other place)				and 20879
ian cal ner management	Evalillie	4 Donation 5 Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contr	mplications that caus y one cause on each  Due to (or a b).  Due to (or a c).	ed the death. Do no	Inc.; 600 Ken enter the mode of dying, st	Facility R.  nedy St  uch as cardiac of	reet, N.	W.; Washing	Morticians, ston, D.C. 2001 Approximate Interval Between Onset and Death
ror use as	ysicialiymedica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 Fetal death t at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
2 8	<u>`</u>	Part II. Other significant conditions	contributing to death	but not resulting in t	ne underlying cause given in	Part I.	23e. Did to	a	to the cause of death?  Probably 4 Unknown
page 2 snould	animo						24a. Was autor perfo 1 □ Yes	psy prior prior death	autopsy findings available to completion of cause of ?
To Be (	20	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No		atient 2 ER/Outp	atient 3 DOA Other:		me 5 ☐ Resi	dence 6 ☐ Other (S	pecify)
i c		27. Manner of Death	28a. Date of I	njury 28b. Tir		_	28d. Describe I	how injury occurred	
in by the fu		1 ∯rÑatural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ho		M Work? 1 □ Yes  n, street, factory, office		28f. Location (8 City or Tox	Street and Number or wn, State)	Rural Route Number,
completely filled in by the funeral director, page  Medical Certification: To Be Com		2 Accident 3 Suicide 4 Homicide  29a. Certifier  29a. Certifier	be 28e. Place of building,	Injury - At home, farmetc. (Specify) est of my knowledge, s of examination and	M 1 □Yes	date and place,	City or To	wn, State) cause(s) and manne	r as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} APRIL **Physician** 8:50 A M PETERSON PEARLY **EDWARD** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES HYATTSVILLE 5101 70th PLACE | House | Hours | Min. | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | Nov | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 A M 2 ☐ F **Funeral** Months SOUTH CAROLINA Yrs. 54 577-74-8108 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It is Medical Exprimer Invar Le rediffed at 1 Yes 2 No Director HYATTSVILLE PRINCE GEROGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20785 5101 70TH PLACE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married BLACK 1 □Yes 2 X No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE LANDSCAPING 11TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE CLEMONS WILLIE PETERSON ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10415 GLEN MANOR DRIVE BOWIE, MARYLAND permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. VERLETTER CURRY/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND 4/17/2009 HARMONY CEMETERY J. F. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOMYOPATHY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physician and use as the burial-transit DIABETES MELLITUS resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy atten for u Month Day 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown HEPATITIS C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy 1 ☐Yes 2¾ No 2K□No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 ☐ Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, reral Director; / after death within 24 hours a

To the Funeral C

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D 0062165

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

person who completed cause of death (Item 23a) (Type, Print)

7582 ANNAPOLIS ROAD LANDOVER HILLS, MARYLAND 20784 TESHOME TEGENE M.

State Registrar

Medical

29a. Certifier

Amended #1 09-02854 Phyllis Rymer	, I		ease Typ	oe or Print ate of Mary	in Bl	ack Ind	lelible						gible	_		
, ,		- For State	0.	ate of mary	idi id		ificate c				J. 1.17		eg. No.	2	0 0	9 1363
Physicia Medical Examir	n/	1. Decedent's Nam	ne (First, Midd HYLLI	LOIM		E YMER						Date of Dear Month April 9, 20	Day 109	Year		Time of Death 2157 hrs
		4a. Facility Name ( 1047 Nation		-	number)			4b. City, La V		ocation of	Death			. County of E Jlegany	eath	
Funeral	4	5. Social Security		6. Sex	7. Ag	e (In yrs. las	t birthday)		ler 1 Year	If Under	24Hrs.	8. Date of Bir	1	DD/YYYY) 9		lace (State or
Director		212-24-3	2001	1 M 2 XF		80	Υ	Mont rs.	hs Days	Hours	Min.	12-1	1 - 1	1928	oreign Count	try) MD
Ą	-	Usual Residence o	of Decedent 10b. County			10c City T	own or Loc	ation							1	Od. Inside City Limits
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vith the Maryland 23a or 28a-f show r polified at once.	Director	10e. Street and Nu	<u> </u>						p Code			1	0g. Citi:	zen of What	Countr	y?
h the N 3a or 2		9 HELM	AN D	RIVE					502					SA		
eath wit	Funeral	11. Marital Status  1 Never Marri	ied 2 🐋	farried Armed	Forces?							cify Yes or No lican, etc.)	)-	14. Race - A White, e		n Indian, Black,
fter de		3 Widowed	4 Dir	vorced If Yes, Give		X No	1	Yes	2X No	specify:				Specify: W	ніт	E
nours a	ed by			or Dates: ecify only highest g		, , ,	16a. Deced			on (Give k			16b. I	Kind of Busin	ess/Ind	ustry
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s, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Meckel Examiner.		17. Father's Name	(First, Middle	e, Last)		1				18. Mother's	s Name (	First, Middle,	Maiden	Surname)		
2121 ould be fill marked ic event,	Be	WILL]	IAM HI				I 10h Mail	ina Addros		LILL.		RUSS			C K	Zin Code)
MD 2 d 2 shoul lith and M n 27 is m	P.			L/DAUGE	TER							VALE,			State, 2	up code)
re, N I and I Health fitem	-					1		111 111				Date		Location - C	ity or To	own, State
Baltimore, permit. Pages 1 at Department of Her Important: If ite	20a. Method of Dis 1 X Burial 2 4 Donation	HILL	CREŚT	MEMO	RIAL	PARK	4/	15/200	9	CUMBE	RLA	ND, MD				
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be nofified at once.		21. Signature of F	uneral Service	e Licensee			i			of Facility	SUA	RPELLI				
Physician	$\dashv$	23a. Part I. Enter t	the disease, o	or complications that	cause	the death.	Do not ente	r the mode	of dying,	such as ca	ardiac or	CUMBERL respiratory ar	rest, sh	ock, or heart	1302	Approximate Interval Between Onset and
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Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		Part II. Dther sign	nificant cond	litions contributir	g to dea	th but not re	sulting in th	e underlyi	ng cause	given in Pa	art I.					ne cause of death?
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Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier	Certifying	Physician: To the	best of	ny knowled	ge, death or	curred at	the time, d	ate and pla	ace, and	due to the ca	use(s) a	and manner a	s state	d.
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6		30. Name and ad	dress of perso	on who completed	cause of	death (Item					<del></del>					
MUS		Laron Loci		Assistant Med		caminer	111 Pe	nn Stre	et, Balti	more, M	ID 212	01				
S Regis	tate trar															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rymer Perry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany
Birthplace (State or Foreign
Country) WMHS--Memorial Campus umberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr 11, 1 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Months 1 → M 2 □ F 218-16-4927 82 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exeminal roust be multiped at LaVale 1 □Yes 2 □ No MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21502 USA 9 Helman Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WWII δ. white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kelly Springfield electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Louise Wilt Rymer Frederick Carson Rymer မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 1027 Weires Avenue LaVale Susan Michael daughter other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4/15/2009 Hillcrest Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart fair re. Lisyonly one cause for each line. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Omnitas Examiner motoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical aftending p 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown auture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certification: To Be examiner? 120 Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA this ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ACCIDENT AUTO 5 ☐ Pending investigation 1 Natural
2 Accident PASSANGER 1 ☐ Yes 2 ☐ No 4/9/09 2162 within 24 hours after death

To the Funeral Director: A completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1047 NATIONAL HAY CAVAGE MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier @ 2007 MD.

State Registrar

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DHMH 17 Rev 1/2001

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32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOLM

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8:00 PM 2009 April Robert Lee Reed /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 26,1938 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Maryland 214-36-0167 Jan. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location ral", or Items 23a or 28a-f show 10a State 1 Yes 2 No Funeral Director Washington County Clear Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21722 14026 Dry Run Rd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Completed by White 3X Widowed 4 □ Divorced It of Health and Mental Hygiene.
If item 27 is marked other than "natural" or other traumatic event, I'm Medical Ex 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oil Company Delivery Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Reed Helen Guessford Reed ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8991 Crocket Dr. Lantana, TX 76226 Brian K. Reed-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Broadfording Church 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If iten any Injury or ott once. 1 N Burial 2 □ Cremation 3 □ Removal from State 4-18-2009 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown. MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (F disease or condition resulting in death) mediate Cause (Final neumonia **Physician** IM Y dethor /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No : After this c funeral dire 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P 31. Date filed (Month, Day, Year) State APR 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $11^{pay}, 2009^{ear}$ **Physician** Francis L. Stueckler 3:45P. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4300 Birmingham Place Beltsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April 22,1929 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours Washington, DC 1**X** M 2□ F 79 578-34-4208 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show Examiner must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 2 Z No Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5 20705 4300 Birmingham Place United States "natural", or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 1946-1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (9-12) Health and Mental Hygiene. tem 27 Is marked other than Mechanic **PEPCO** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Stueckler Effie Hansen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Birmingham Place Beltsville, Maryland 20705 Norma J. Stueckler -Wife item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 4/18/2009 Alexandria, Virginia 20a. Method of Disposition permit. Pages 1
Department of IImportant: If Ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Morald Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Respiratory Failure 2months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Non Small Cell Lung Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

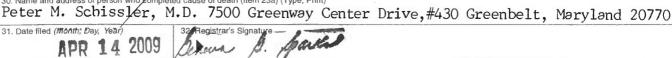
To the Funeral Director: After this certificate has been signed by the attending physiciar. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive Pulmonary Disease 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2**X** No 1□ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month; Day, Year, 14 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D22780

29d. Date signed (Month, Day, Year) April 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Anna Elizabeth Starbard April 8. 2009 11:09 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 🕱 F Months Days Hours 28, 1923 Pennsylvania Director 85 196-18-0503 Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 10a State 10b County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified. 1 □Yes 2 X No Director Montgomery Village Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 9960 Hellingly Place United States 20886 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify Specify: 2 3 ☐ Widowed 4 🔀 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Florence Miller W. Pope Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur Gaithersburg, Maryland 20879 Gail Crook/ Daughter 19600 Framingham Dr., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/10/2009 | Alexandria, Virginia 21 Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Pulseless Electical Activity /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consequence of) sician and burial-transit the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🖾 No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes, Hypertension page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₩ No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? he Hospital or Attending P in 24 hours after death. he Funeral Director; After t pletely filled in by the funera 28d. Describe how injury occurred After t 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Regist<u>rar</u>

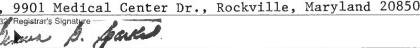
APR 14 2009 Certain

Santosh G. Rane,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.



Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division of Vital

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#19aperINF, 4/15/09, BWW, MoCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jane Schooley 0900 April 10, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Hours Months Min. 1 □ M 2 🕅 F February 16, 1924 086-16-8500 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Silver Spring Montgomery MD 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA. 20902 11504 Veirs Mill Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Retail Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Odessa McDonald Wilmer E. Bowen ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) James J. Schooley 13804 Parkland Drive, Rockville, MD 20853 James J. Partain -Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 15, Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULLDONALY Physician HRONIL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ Ño 24a. Was an autopsy performed 2 **2**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director; / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

within 24

29b. Signature and title of certifier

Truong Bao

3. Registrar's Signature 31. Date filed (Month, Day, Year) 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

~, MD

10110 Molecular Drive, Rockville, MD 20850

29c. License number

00057124

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMFND#23bperMD4/14/09, FMW, Moo Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April ^{Day} 2009 Murray SCHNEIDER 8:00 P M **Physician** 8, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Year New York Days Hours 80 1928 062-22-7006 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Examir or must to nothed at 1 ☐Yes 2 No Director Rockville Maryland Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20852 United States 11801 Rockville Pike #415 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Myes 2 No If Yes, Give Year or Dates:Korean 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Economist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Borel Nathan Schneider ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Providence Lane, Howell, NJ 07731 Paul Chasinov, Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cother (Specify) Judean Memorial Gardens 08/12/09 Olney, MD 21. Signature of Funda Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARCINOMA Immediate Cause (Final disease or condition resulting in death) ESO PHAOUS OF **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pyrsequence off Physician/Medical Examiner O. Box 68760, 0 he law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?

1 Yes 2 No Perrove
9 Unknown TILM 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) After this certificate has be n signed by the funeral director, p.ge 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death,
neral Director; / 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated.

Records, Division of Vital Hospital or Attending Physician: within 24 hours at To the Funeral D completely filled it the 2

EIDER, MURRA,

O

State Registrar 29b. Signature and title of certifie

21 MONTROSE RO 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10+1

29d. Date signed (Month, Day, Year)

Amend 04/16	ded #5,	)c n] 11 <i>e</i>	ls, per fd,	Please											
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	Physicia		1. Decedent's Name (Fi	irst, Middle, La	S'NATT	-11 <	SR.				2.	Date of Dea		200:	3. Time of Beath O
0	/Medic Examin		4a. Facility Name (If not		re street and number)	HI		4b. City,	Town, or	Location of	f Death	IIVT	4c.	County of Dea	ith
	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA		PLEASANT.  5. Social Security Number				SME last birthday	M OI If Under	1 Year	If Under 2	CRY 24 Hrs. 8.	Date of Birtl		-HKK	thplace (State or Foreign
	Funeral Director		217-42-695 233-56-79 Usual Residence of Dec	95	1 <b>∑</b> M 2□F	69		Months	Days	Hours	Min.	(Month, Day PR. 24	, Year)	C	ountry) ST VIRGINIA
	72 hours after death with the Maryland Inatural," or items 23a or 28a-f show drai Examiner must be notified at	tor	10a. State 10l	b. County MINER	AL		, Town or L								10d. Inside City Limits 1 □ Yes 2 ▼ No
	with the la or 28a t be noti	Funeral Director	10e. Street and Number			1		10f. Zip	Code 6719	)				zen of What C	ountry?
	r death	ınera	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Deced	lent of Hi	ispanic Orio	jin? (Specify , Puerto Ric	y Yes or No- an, etc.)		14. Race - Am Black, Whi	
9036	ours afte	by	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 XYes 2 ☐ If Yes, Give Year or Dates:		61	1 ☐ Yes		Specify:					VHITE
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Maryland 21215-0036	ould be fi Mentai H arked otl atic ever	To Be	17. Father's Name (Firs	·								DUGGII		Surname)	
Man	ind 2 sho alth and 27 is ma ir trauma		19a. Informant's Name									oute Numbe SHBY , V		r Town, State, 26719	Zip Code)
O 0 5 = 6   1 ⊠xBurial 2 □ Cremation 3 □ Removal from State   cemetery, crematory or other place)										cation - City or					
altin	rmit. Papartme portant portant y injury ce.		4 □ Donation 5 □			F OR	T ASHI	2.000	6.5.6.		· · · · · · · · · · · · · · · · · · ·	IOME,		ORT ASI	HBY, WV
<u> </u>	<b>8 3 E 6</b>		23a. Part1. Enter the d		polications that cause		Do not er	P.O.	BOX	1260	, FOR	T ASHI	BY,	WV 26	719 Approximate
	Physician		shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only	one cause, n each l	ine.	DON	- 100		(701	-	oopiiatory an			Interval Between Onset and Death PIVE PAYS
4	/Medical Examiner				Due to (or as	a consequ	uence of):								Meero
	rted nsit	Examiner	Sequentially list condition any, leading to find eccuse. Enter Underlyin Cause (Disease or injur	ons,	c. SEVERE ALZHEIMER'S DEMENTIR							rî A		Six kindley	
90,	oe executed cian and ourial-transit		that initiated events resulting in death) Last	ı	Due to (or as	a consequ									21/2 /(1/02/
687	ifficate g physi as the b	edica			_d										
.O. Box 68760	Physician: The law requires that the death certificate be at this certificate has been signed by the attending physician rat director, page 2 should be detached for use as the burn	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					2	23d. Date of de Month	llivery Day Year
JS, P	ires that signed b	by	Part II. Other significan	nt conditions	contributing to death b	out not resu	ulting in the	underlying ca	ause give	en in Part I.					o the cause of death?
corc	aw requires that s been signed to should be deta	Completed									—	1 □ Y 24a. Was a			robably 4 Unknown  utopsy findings available
al Re	sician: The lav certificate has rector, page 2 s	Comp										autop: perfor 1□ Yes	sy med2 2 No	l death?	utopsy findings available completion of cause of
\ Ki	rsician: Th s certificate lirector, pag	o Be	25. Was case referred texaminer? 1 ☐ Yes 2 ☑ No	to medical	Hospital: 1 □ Innati	ent 2 🗆	ER/Outpatie	nt 3 🗆 DC	Δ Othe	_		heck only or		3 □Other (Spe	anife)
n or	ing Phy offer this	on: To	27. Manner of Death	☐ Pending	28a. Date of Inju (Month, Da	ury	28b. Time Injury		8c. Injury Work			I. Describe h			эспу)
Division or Vital Records, P.O.	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Certification:	2 Accident	investigatio Could not b determined	e 28e. Place of in	jury - At ho tc. (Specify	me, farm, s	M reet, factory		Yes 2□N		Location (S City or Tow	treet and	d Number or F	ural Route Number,
Ō	spital or ours afte leral Dir filled in			Certifying Pl	hysician: To the best			th occurred	at the tim	ne date and	d place, and				e etated
	the Hos nin 24 ho the Fun npletely	Medical	(Check only 2 one)	Medical Exa	miner: On the basis of and manner st	of examinat	tion and/or i	nvestigation	, in my o _l	pinion, deat	th occurred	at the time,	date and	place, and du	e to the cause(s)
	9+	2	29b. Signature and title	of certified	less				-	Soit-	69	1	PR	e signed (Mon	th, Day, Year)
	nas		N.B. VELLAN	of person who	completed cause of 6	death (Item	23a) (Type	Print)	KWI	TY TA	308				
	Sta Registr		31. Date filed (Month, D	6 2009	Sexuel 32. Registr	rar's Signat	far.	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 09 **Physician** 04 11 0835 KATHERINE ANN SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner Allegany** Cumberland WMHS Braddock Campus If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign
Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 XF Yrs. 63 VIRĞINIA MAY 19,1945 217-42-6952 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Evannings and be notified at 1 □Yes 2 No Director CUMBERLAND ALLEGANY MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or 3 21502 11708 BAYBERRY AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items Black, White, etc. 1 □Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ALLEGANY COUNTY BOARD Elementary/Secondary (0-12) College (1-4or 5+) OF EDUCATION ACCOUNTS PAYABLE CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSE A. VANMETER JOSEPH M. BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11708 BAYBERRY AVENUE, CUMBERLAND, MD J. ROBERT SMITH / HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State SUNSET MEMORIAL PARK 04/15/2009 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21. Signature of Funeral Service Licensee 21502 Lepchelle 23a. Part 1. Enter the dis t se, or complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En or underly Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): and the burial-tran Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) detached 9 Unknown s been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To Division of Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending investigation 1 □Yes 2 □No or.
safter dec.
al Director; 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 11 2007 026907 8

State Registrar

Saltimore, Maryland 21215-0036

925 Bishop Walsh Rd Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1908 P M 2009 APRIL 17 Thomas Savage Michael /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany WMHS- Braddock Campus Cumberland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F Yrs. 57 Virginia 05/09/1951 West 220-58-0278 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be netflied at 1 ☐ Yes 2 No Directo MD Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 15506 Winslow Street, SW USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Millwright Ballistics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental item 27 is marked or Whelan Russell Savage, Sr. Dorothy Louise Henry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is I 15506 Winslow Street, SW, Cumberland, MD Debra Savage / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. Cumberland Crematory | 04/18/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Sign fun of Funeral Service Licer 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 Hours Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year o in the past 12 months? 5 Other (specify) ed by the a 9 T Unknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1X Natural Division 5 Pending within 24 hours after common to the Funeral Director: Aft 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0014865 April 18, 2009 5 · MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes Robustiano J./Barrera, M.D., 500 Memorial Avenue, Cumberland, MD 31. Date filed (Month, Day, 32. Registrar's Signature Year) State APR 20 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 13641

Arthur W. Slaughter	State O	f Maryland / Depar	rtment of tificate of	Health and	d Mental I		201	09 1364
	Registrar  1. Decedent's Name (First, Middle,Last)	Cert	ilicate of	Dealli ————		2. Date of Dea	eg. No. th	3. Time of Death
Physician/ Medical Examiner	ARTHUR WARREN SLAU	ICHTER				Month April 6, 20	Day Year	1855 hrs
	4a. Facility Name (if not institution, give s	treet and number)	41	o. City, Town, or	Location of Dea	ath	4c. County of Death	)
	Easton Memorial Hospital			Easton			Talbot	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		C	th(MM/DD/YYYY) 9. Bir Foreig	an
Director	214-42-7698 1XXA	1 2 F 64	Yrs.	Months Days	I Hours	AUGUST	24, 1944 co	untry) MD
×,	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location	np				10d. Inside City Limits
ow an		,	ROYAL O					1 Yes 2 XXNo
yland a-f sh t once	MD TALBO	l I	MIDI O	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
the Maryland or 28a-f sh	25684 EDGEVIEW R	D.			662		USA	
		12. Was Decedent Ever in U.S	5. 13. Was	Decedent of His	spanic Origin? (	Specify Yes or No		ican Indian, Black,
r death with or items 23 must be no Funeral	1 Never Married 2 XXMarried	Armed Forces?  1XX Yes 2 No	If Ye	s, specify Cuban	ı, Mexican, Pue	erto Rican, etc.)	White, etc.	
		Yes, Give Year or Dates:		Yes 2 XX No			Specify: WHI'	
hours after "natural"; Examiner	15. Decedent's Education (Specify only			's Usual Occupat est of working life			16b. Kind of Business.	(Industry
36 n 72 h nan "r lical E	Elementary/Secondary (0-12)	College (1-4 or 5+)		CATTOMA	L INT		BEVERAGE	
15-0036 Teld within 72 hour Hygiene. d other than "natt it the Medical Exam."; the Medical Exam.	12 17. Father's Name (First, Middle, Last)	2	<u> </u>	SALESMA		ame (First, Middle,	Maiden Surname)	
215. be filed ntal Hy rked of ent, the	CLIFTON SLAUGHTER				LOR	RAINE COI	LEMAN	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by	19a. Informant's Name/Relationship (Typ	pe, Print )	1				mber, City or Town, Stat	
MD nd 2 sho alth and alth and m 27 is aumati	LINDA SLAUGHTER W						AK, MD 2166	
re, s l and f Heal f iten	20a. Method of Disposition  1 XXurial 2 Cremation 3		Place of Disposi rematory or oth	tion (Name of ce er place)	metery,	Date	20c. Location - City o	r Town, State
altimore, mit. Pages la partiment of the portiment: If ite iury or other ti	4 Donation 5 Other Specify:	MD '	VET CEM	ETERY		4-15-09	HURLOCK,	MD
Balti permit. Departi Import	21. Signature of Funeral Service License		∩ 22 N	LLOWS,	ELFENB	EIN & NE	WNAM FUNERA	L HOME, P.A.
	23a. Part I. Enter the disease, or complic	Proush C.F.S.	Do not optor th	O S. HAI	RRISON	ST. EAST	ON, MD 2160	Approximate Interval
Physician /Medical	failure. List only one cause on each	n line.	Do not critici a	ic mode of dying,	, 000, 00 00, 010	, , , , , , , , , , , , , , , , , , ,		Between Onset and Death
xaminer		ead Injuries ue to (or as a consequence of	7)					-
No.	Sequentially list conditions, b	30 (0) (0) 40 4 00004 0000	,-					
ner	if any, leading to immediate D cause. Enter Underlying Cause	ue to (or as a consequence of	f):					
ed nsit Examine	City as a criminal that initiated	ue to (or as a consequence of	f):					
executed an and al - transit					() mm			
	UNPENDED	AMENDED 28f,per	ME,g89U	4/29/0	9 11			
760, icate be physic the bur	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregi			Ectopic pre	anana.	23d. Date of delive Month	ry Day Year
ox 68760 anh certificate attending phy for use as the b	past 12 months?	Live birth     Pregnant at time of de	- 11	tal death 3 ner (Specify)	Ectopic pre	egnancy	Month	Day Teal
Box e death of the attented for us	1 Yes 2 No 9 Unknown	g Unknown	O Ou	iei (opoon)/				
tal Records, P.O. Box 6876 cian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the Be Completed by Physician/M	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		tobacco use contribute t	
i, P.( ires tha signed to by		<u> </u>				212.00	es 2 V No 3 Pr	
of Vital Records,  ng Physician: The law require ther this certificate has been signeral director, page 2 should b.  To Be Completed							ppsy prior to	autopsy findings available completion of cause of
lecc he lav ate ha age 2						1 ✓ Yes	ormed? death?	
Vital Recysteinn: The last certificate director, page	25. Was case referred to medical examiner?			26.Plac	e of Death (Ch			
F Vit	1 ✓ Yes 2 No	ospital: 1 Inpatient 2				ursing Home 5	Residence 6 Oth	er:
ing Physi After this funeral dir	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Apr 6, 2009	28b. Time of I 1755 hrs		ury at Work? Yes 2 ✔ No	Driver auto	e how injury occurred  ofixed object collis	ion
Division of spiral or Attending nours after death.  Tental did in by the fun Certification	Natural 5 Pending  2  Accident Investigatio						(Street-and Names or	Rural Route Number. City
Nor A	3 Suicide 6 Could not b			et, ractory, onice	building, etc.	or Town,	State SK-328	PurBlatekumbogity Alley
	29a. Certifier	n: To the best of my knowled		red at the time	date and place	and due to the car	use(s) and manner as st	Englon, Mi
To the He within 24 To the Fu completel	one) 2 Medical Examiner:	On the basis of examination a	nd/or investiga	tion, in my opinio	n, death occurr	red at the time, dat	e and place, and due to	the cause(s)
To To Com	29b. Signature and title of certifier	and manner stated.			se number		29d. Date signed (A	
	1 ( May ) L	d		0.0	.M.E.		April 7, 2009	
	30. Name and address of person who co							
AV+EI		Assistant Medical Exar	miner 111	Penn Stree	t, Baltimore	e, MD 21201		
State	MER I.3 /II	09 32. Registrar's Signatu	A ha	Mad				

State Registrar

1401

#327

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince

Bannen

31. Date filed (Month, Day, Year)

rince Philip
32. Registrar's Signature

			For State	State of Mary					2000	12012
			Registrar		Cer	tificate of	Death 	2. Date of Death	g. No. 2 U U	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Month .	Day Year	2 1
	/Medio Examin		DORIS GRAHAM  4a. Facility Name (If not institution, give	SHIRK street and number)		4b. City, Town, o	r Location of Death	HIPLIT	4c. County of Dea	
,	LXAIIIII	C1	FAHRNEY-KEEDY HOM	E		BOO	ONSBORO		WASHIN	
Т	Funeral		Social Security Number     6. Security Number	TM OFF	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MARCH 24	Year) 9. Bit	rthplace (State or Foreign ountry)
	Director		491-05-0572 Usual Residence of Decedent	9	1 Yrs.			MARCH 24	, 1917 M	ISSOURI
	land ow		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MARYLAND WASHING	TON		BOOI	NSBORO			1 □ Yes 2 <b>X</b> No
	or 28	Jire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	•
	death with the Maryland tms 23a or 28a-f show	Funeral Director	8507 MAPLEVILLE R				713		U.S.	
	items	nne	Tr. Mariar Olavao	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No	in U.S. 13. V	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
35	ırs aft Ir, or xard	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2【 No	Specify:		Specify:	WHITE
2-003b	2 hou		15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	oation during most of work		16b. Kind of Business	s/Industry
N N	thin 7 ne.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d)			BIGING IAS
2	led wi lygier her th	ပို	13 5 H 1 N 1 (Fine bridgle I N)	1		SECRET		e (First, Middle, N	APPLIED PI	HYSICS LAB
and	i be fil ntal H ed ot	Be	17. Father's Name (First, Middle, Last) CHASE P. GRAHAM				Stella M	•	iaiden damame)	
Ž	should nd Me mark mark	ို	19a. Informant's Name/Relationship (7)	/pe. Print)	19b. Mailin	na Address (Street			City or Town, State,	Zip Code)
Ma	nd 2 sallth ar		MALINDA SHAVER/DAU		P.O.	BOX 969.	MARTINSB	URG, WES	T VIRGINIA	A 25402
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinating mast be nutfilled at once.		20a. Method of Disposition	2	20b. Place of Dispo cemetery, cren				20c. Location - City o	
Ē	Page nent ant: If ury ol		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	STAUFFER	-		2009 F	REDERICK,	MARYLAND
air	permit. Departr Importa any inju		21. Signature of Jury al Service I cen-			. Name and Addre	ess of Facility BA	ST-STAUF	FER FUNERA	
Ц	20 E # 9		1 cent Mill	Paul M.					nsboro, M	
			23a. Part I. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Deme						167
*	Examiner			Due to (or as a co	onsequence of):					,
		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence of):					
	cuted od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events	c.						
Ď,	e exe ian ar ırial-tı		resulting in death) Last	Due to (or as a co	onsequence of):					
2/PU	ficate be executed physician and s the burial-transit	dical		d		··- ·				
٥	certific nding p ise as		IF FEMALE:	23c. If yes, outcome of p	regnancy				22d Data of d	olivera
X Q	atte for u	sician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	Day Year
j.	the d y the ched	Physi	1 ☐ Yes 2 TNo 9 ☐ Unknown	9 Unknown						
~. 	requires that neen signed b	by Pi	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ğ	quire en sig uld b							1 □ Ye	s 2 □ No 3 □ I	Probably 4 M Unknown
ပ္	0 % CJ	Completed						24a. Was ar		autopsy findings available ocompletion of cause of
	The cate h	Som						perform 1 □ Yes 2	ned? death?	
VITal	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?	Hospital:		Tot	hori	th (Check only on		
0	Physical this call direction	٦.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier	1 3 DOA			ence 6 Other (Sp ow injury occurred	ecify)
_	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye		Wo	rk? ]Yes 2∐No	ZOG. DOSONOC NO	Williamy occurred	
DIVISION	Attending ir death. ector: Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	Zoe. Place of injury	- At home, farm, str	eet, factory, office			reet and Number or I	Rural Route Number,
S	al or s after	Certification: To	4 ☐ Homicide determined	building, etc. (5	Specify)			City or Towr	i, State)	
	To the Hospital or Attending Physician: The I within 24 buts after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical (	(Check only 2 Medical Exam	ysician: To the best of miner: On the basis of ex	amination and/or in	h occurred at the livestigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated	<u>.                                    </u>	29c. Licen	se number	2	9d. Date signed (Mor	nth, Day, Year)
	F 18 C 0						(2323		64-16-	
			30. Name and address of person who c	ompleted cause of death	h (Item 23a) (Type.		3 -3		1	
افا	H-15		Khalid M. Waseem.				erstown,	Maryland	21742	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's						
	Regist	rar	APR 17 3	009	(a) A (a)	hadd				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Day **Physician** Douglas D. Singleton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE BARTIMORE WARHINGTON MEDICAL CRUTER AMNE ARUNISEI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Social Security Number Year) 1**⊠**M 2□ F Months Days Hours 44 059-64-6019 Oct. 4, California Director 1964 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Modical Experiment to confine an once. 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21114 USA 1752 Remington Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Robert W. Singleton Anne Sorohan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Erin C. Singleton / Spouse 1752 Remington Dr. Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 4/16/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List dupone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN METASTA MELANOMA WITH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 ☑ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manger of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes n 24 hours after death. Re Funeral Director: A bletely filled in by the fi 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated

within 2

State Registrar

31. Date filed (Month, Day Yar) APR 13

29b. Signatus and hale of certifie

30 Name and address of person who

death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 8:00 pm April 16 2009

4b. City, Town, or Location of Deeth 4c. County of Death Bonnie W. 4a Facility Name (If not institution, give street and number) Scott /Medical Examiner Silver Spring
| If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Montgomery

9. Birthplace (State or Foreign Country) Springbrook Nursing & Rehab If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Yrs. 79 09/05/1929 Michigan 363-30-6836 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Sterling Loudoun 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 46565 Harry Byrd Highway Apt 229 20164 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black \$ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Love Bobbie Conley 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sterling, VA 20164

Date 20c. Location - City or Town, State 153 Kale Avenue Patricia A. Scott Timus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adams-Green Funeral Home 04/24/09 Herndon, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams-Green Funeral Home 721 Elden St., Herndon, VA 20170 23a. Part1. Enter the dis set, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Instant Cardiac Arrythymia Examiner Due to (or as a consequence of): Examiner Congestive Heart Failure 3 months The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and Division of Vital Records, P.O. Box 68760, Coronary Artery Disease Physiclan/Medical Due to (or as a consequence of) for 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. the completely filled in by the funeral director, page 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown <u>Chronic Kidney Disease</u> þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 XNo 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 X Nursing Home 1 ☐ Yes 2 ☐ XNo 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e t(Xcertifying Fhyeleian: To the beet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 95a Cortflat Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number Mile of certifier 29b. Signature and April 21, 2009 D28656 of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi. MD 15225 Shady Grove Road #208 Rockville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 28 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3646 For Form Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Pour Page 1997 Po Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April # Catherine Maus Tom **Physician** 7:15p/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye November 9, 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number Days Year, **Funeral** Hours Min Months 1 M 2XXF 62 ~1946 174-38-8052 November Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "the Call Event out to notified at Hvattsville 1 ☐ Yes 2 X No Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20783 2507 Amherst Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 201 No 14. Race - American Indian, 11. Marital Status 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 🕅 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Own Home al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname)
Etheldreda M. Yeckley permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Charles F. Maus ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2507 Amherst Road, Hyattsville, MD 20783 Jonathan Tom / Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 15, 2009 St. Michael, PA St. Michael Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial trai resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached fo o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2  $\square$  No 1 ☐ Yes certificate To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA this Certification: To After thi funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident Division 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 [Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Adami 31. Date filed (Month, Day, Year) Registrar's Signat State 2009

DHMH 17 Rev 1/2001

Registrar

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Division or Vital Records, P.O. Box 68760,

			1 - State Registrar		C	ertific	ate of l	Death			Reg. No. 2	009	13647	
ń	Physici /Medic		1. Decedent's Name (First, Middle, L Warren H. T					1	Date of De Month	ath Day	Year 2009	3. Time of Death		
)	Examin		4a. Facility Name (If not institution, g Levindale Hebrew Geri			Ва	City, Town, or 1timor	e Cit	У			nty of Death		
	Funeral Director		213-24-4100	Sex 7. Ag	e (In yrs. last birthd 79 Yrs	Mon	nder 1 Year ths Days	If Under 2 Hours	Min. De	Date of Bir (Month 20 C • 20	, 1929	9. Birthpl Mary	ace (State or Foreign and	
	Maryland a-f show fied at	tor	Usual Residence of Decedent  10a. State Virginia Shenence	loah	10c. City, Town or Star Tar							10	0d. Inside City Limits 1 ☐ Yes 2 1 No	
	The street and Number 8877 John Marshall Highway  10. Street and Number 8877 John Marshall Highway  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married 1  Yes 2 No							54				ng. Citizen of What Country? United States		
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1215-0036	within 72 ho iene. than "natu the Medical	Completed	15. Decedent's (Specify only highest g	Education trade completed) College (1-4or	5+) (G lif	ecedent's live kind of le. DO NO VEYOR	Usual Occup f work done o DT use retired	ation during most d)	t of working			f Business/Ind	ernment	
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	1 and 2 shou Health and N em 27 is ma hther trauma		19a. Informant's Name/Relationship Bonnie Wilson -Da		3548	3 Loc	h Have		ed Edge	ewa te	r, Mər	wn, State, Zip ylənd	21037	
Baltimore,	Pages 1 ament of He tant: If item		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control	oify)		crematory olita	n Cren	atory		/2009	Alexa		wn, State Virginia	
Ball	permit. Page Department of Important: if any Injury or		21. Signature of Funeral Service Lic	revaret		4400	Powde	er Mil	ll Road	d Bel		e, PA e, Mar	yland 20705	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Due to (b) as	a consequence of):	Hea		ig, such as		spiratory a	rrest,	t	Approximate Interval Between Onset and Death	
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):		egui,	5/12	.,,,,,,					
Box	he death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 ☐ Fetal death t time of death		pic pregnancy er (specify)	/			23d.	Date of delive Month	e <b>ry</b> Day Year	
rds, P.O.	The law requires that the death c tte has been signed by the attend bage 2 should be detached for us		Part II. Other significant conditions Parkin Son's	contributing to death to		e underly	ing cause giv	en in Part I.				contribute to the	ne cause of death?	
Division or Vital Records,		Completed by								24a. Was auto perfo 1 Yes		prior to cou death?	psy findings available npletion of cause of 2 No	
r Vita	> . <u>∞</u> ₽	To Be (	25. Was case referred to medical examiner? 1  Yes 2	Hospital: Inpati	ent 2 ☐ ER/Outpa	atient 3	DOA Oth	or:	e of Death <i>(C</i> ursing Home			Other (Specif	y)	
sion o	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural 2 Accident  3 Suicide  6 Could not	ho	ay Year) Inju	ry M		yat k? Yes 2 ☐	No		how injury oc			
Divi	vital or At urs after d rral Direct lled in by		4 ☐ Homicide determine	building, e	jury - At home, farm tc. <i>(Specify)</i>					City or To	wn, State)		il Route Number,	
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Medical	(Check only  Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination and/o			opinion, dea			, date and pla		the cause(s)	
	v in c		29b. Signature and title of certifier	1 MD			De	305	4			10.2		
	-		30. Name and address of person when SIK HUR MO	2434 V	vest be	1 vec	1ere	Ave.	Balt	im or	e. 40	212	ol	
¥	Sta Regist		31. Date filed (Month, Day, Year)  APR 14 2	009 Desam	rar's Signature	ark	J.							

			For State Registrar		State of Ma	aryland		rtment of F <i>tificate of l</i>			giene , Reg. No. [©]	2009	13648
	Physicia	an		ne (First, Middle, La		<u> </u>		-		2. Date of De Month APRIL	ath 24,2	∩∩9 ^{Year}	3. Time of Death 12:30 P M
	/Medic	al			THORNBUR	<u> </u>		4b. City, Town, or	Location of Death			ounty of Death	12.30F
-					ESTWOOD :			BRA	NDYWINE				SEORGES
	Funeral Director		5. Social Security N 219-30-		Sex 7. Ag	e (In yrs. las	1 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 1 – 1 4 –	1918	MD.	place (State or Foreign ntry)
0	ow #		Usual Residence o 10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
Mon	Ba-fsh	Director	MD.	PRINCE	GEORGES			BRANDY	WINE				1 □Yes 2 XNo
4	a or 28		10e. Street and Nu		ECHWOOD :			10f. Zip Code	1 2		10g. Citize	en of What Cou ↑	ntry?
0	ms 23	Funeral	15600 11. Marital Status	DADEN W	12. Was Decedent		13. V	Vas Decedent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No		1. Race - Amer	
5-0036	be lied within 7.2 nous aller death with the maryland tall Hygiene. Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the hadical Evan insertant be notified at	þ	1 ☐ Never Mari 3 ☐ Widowed	ried 2 ☐ Married 4 ☐ Divorced	Armed Forces? 1	No		□Yes 2111 No	Specify:	o rican, etc.)		Black, White,	
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2121	giene.	dwo:	Elementary/Second 12	ondary (0-12)	College (1-4or 5	+)		HOMEMAK			OWN	HOME	
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Maryland	th and Menta 7 Is marked traumatic ev	ဥ		lame/Relationship (				•	and Number or Ru	ıral Route Numb	er, City or	Town, State, Zi	
	an n 2 n 2				R-DAUGHT					OD RD.		NDYWIN ation - City or T	IE, MD. 2061
<u> </u>	0 = 0		4 ☐ Donation	Cremation 3 5 Other (Special		IMM	IANUE	sition (Name of natory or other place L CH • CE	M.   4-2	7-09	BAD	EN,MD.	
Ball	permit. rage Department of Important: If any Injury or once.	J. I	21. Signature of E	uneral Service Lice	M004	79 (		. Name and Addre AYMOND A PLATA	ss of Facility FUNERAL , MD . 20	SERVI	CE,P	. A .	
	hysician	) ) )	shock, or he Immediate Cause	art failure. List only (Final	nplications that caused one cause on each li		Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or conditi- resulting in death)		a. Due to (or as	a conseque	ince of):		WCD10	UPTIC		- 712	-48AAS
	.xammer	Je.	Sequentially list or if any, leading to in	onditions.	b. Due to (or as	a conseque	ince ot):						
Potition	and transit	Examiner	cause. Enter Und Cause (Disease of that initiated event resulting in death)	erlying r injury ts Last	c. Due to (or as	a conseque	nece of):						
. Box 68760,	physician and the burial-transit	edical E	, , , , , , , , , , , , , , , , , , , ,		d	a conseque	ince on.			- 500.			
x 68	ding ph	Med	IF FEMALE:		22a If you guitanma	of prognan							-
O. Box	at the death certified by the attending partached for use as t	Physician/M	23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pregnanc Other <i>(specify)</i>	у		23	3d. Date of deli Month	very Day Year
<b>.</b>	signed by				contributing to death b	ut not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did t	tobacco us	e contribute to	the cause of death?
rds	w requires been sign should be	ed by								1 🗆	Yes 2	(No 3 □ Pro	bably 4 Unknown
Records,	has be	Completed								24a. Was		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Vital F	r this certificate har all director, page		25. Was case refe	erred to medical	T				26. Place of Dea	1 □ Yes	2 <b>N</b> No		2 □No
Į .	nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 20	No	Hospital: 1 ☐ Inpati	ent 2 E	R/Outpatier	t 3 DOA Oth		lome 5 Resi		☐Other (Spec	ify)
0 00	After th funeral	ion:	27. Manner of Dea	5 Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injur Wor	ryat k? Yes 2 □ No	28d. Describe	how injury	occurred	
Division of	To the hospital or Attending Fribation; The law requires that the value of the formal state death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6	28e. Place of Inj	ury - At hom c. <i>(Specify)</i>	ne, farm, str	eet, factory, office	163 2 110	28f. Location ( City or To		Number or Ru	ral Route Number,
- ::	e nospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one)	Certifying P	hysician: To the best miner: On the basis of and manner st	of examination	ledge, deati on and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
į	withir To th	Me	29b. Signature and	d title of certifier	>		2	29c. Licens	le number 185	45	29d. Date	signed (Month	, _{Day, Year)} 24, 2009
			30 Name and	res of reson who	completed cause of	leath (Item	23a) (Type,	Print) OCL	LIDE	180	El	WAR	Def Hd.
	Sta		31. Date filed (Mo	nth, Day, Year)	32. Registr	ans Signatu	ire &	1 - 00 1	,				20602
DHM	Registr H 17 Rev 1/2			Ark Z	o suna lo	enma	A.	17 Extend					

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		-	For State Registrar		State of Ma	aryland /		ment of F <i>icate of</i> .			giene Reg. No. 2 (	09	13649
ı			negistrar     Decedent's Name	e (First, Middle, L	.ast)		-			2. Date of De	ath	Vear	3. Time of Death
-	Physicia /Medic			nn Vought						Month 04	Tay 17	0°9°	1900 м
and the same	Examin Funeral Director			addock (		e (In yrs. last bi	irthday) If		r Location of Deater  r Land  If Under 24 Hrs  Hours Min.	8. Date of Bir	A.		ny olace (State or Foreign nsylvania
	and w		Usual Residence of 10a, State	Decedent 10b. County		10c. City, Tow	n or Location	on				1	0d. Inside City Limits
	Maryla	to	Maryland	Alleg	anv	Frostb							1 □Yes 2 □No
	or 28g	Director	10e. Street and Nur		Furnace Hill Rd	1.	1	0f. Zip Code			10g. Citizen of	What Cour	ntry?
	eath w	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Was	21532-	lispanic Origin? (5	Specify Yes or No	U.S.A.	ace - Americ	can Indian.
-0000	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show diest Examination colling	þ		ied 2 Married 4 Divorced	Armed Forces?	No		s, specify Cuba Yes 2 No	lispanic Origin? (s an, Mexican, Puer Specify:	to Rican, etc.)	Spec.	ack, White,	etc.
2	72 hor	Completed	(Spec	15. Decedent's cify only highest of	Education grade completed)	16a	a. Decedent	's Usual Occup of work done	oation during most of wo	rking	16b. Kind of I	Business/In	dustry
171	within iene.	dwo	Elementary/Seco	ndary (0-12)	College (1-4or 5	5+)	life. DO l <b>Mainten</b>		a)		School	system	
and	id be filed ental Hyg ked other ic event,	To Be C	17. Father's Name		st)				18. Mother's Na	me (First, Middle,	, Maiden Surna	me)	
mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is and Mental Hygiene. and Industrial is a same any injury or other traumatic event, the Marylan Experimental expension on the remainder on the remainder on the remainder on the remainder on the remainder on the remainder on the remainder on the remainder on the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remainder of the remai		19a. Informant's Na	•	(Type. Print) wife	19	0	ddress <i>(Street</i> urnace Hill	and Number or R	ostburg		n, State, Zip r <b>yland</b>	21532-
ore,	ges 1 a t of He If item or othe		20a. Method of Disp		☐ Removal from State	20b. Place o	of Dispositio ery, cremato	n (Name of ry or other plac	ce)	Date	20c. Location	- City or To	own, State
allimor	nit. Pag artmen ortant: Injury	- 1	4 ☐ Donation  21. Signature of Fu	5 ☐Other (Spec	cify)	Cui	-	Cremator	'	April 18, 2009	Cumberla	ind M	faryland
ם מ	Dep.			lun R	Duris	_			ral Home, 5	7 Frost Ave	., Frostbur	g, MD	21532
	Physician /Medical	1	23a Part 1. Enter the shock, or head Immediate Cause of disease or condition resulting in death)	rt failure. List on (Final	mplications that caused ly one cause on each lin	ne. S S	ynd.	ne mode of dyin		ac or respiratory a	rrest,	ia	Approximate Interval Between Onset and Death
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E.	pe țis	iner	cause. Enter Unde Cause (Disease or	or saviints	Due to (or as	a consequence	of):						
oc,	oe execute cian and ourial-trans	I Examiner	that initiated events resulting in death) I		cDue to (or as	a consequence	of):						
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O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months? ☐No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		topic pregnand her <i>(sp</i> ec <i>ify)</i> _	ey .			ate of delivers	ery Day Year
ds, r.	uires that t signed by d be detac	by	Part II. Other signif	ficant conditions	s contributing to death b	( )	in the under	lying cause giv	ren in Part I.		obacco use co		he cause of death?
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VISION OF	nding tth. :: After e funer	ation	1 Natural 2 Accident	5 Pending investigat	(Month, Da		Injury	28c. Injui Wor M 1	yai k? Yes 2 □ No	260. Describe	how injury occu	irred	
DIVIS	al or Atter s after dea l Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	20e. Place of Inj	ury - At home, f c. (Specify)	arm, street,	factory, office		28f. Location (. City or To	Street and Nun wn, State)	nber or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 or	Medical C	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis o and manner st	of examination a							
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•	nrs		30. Name and addr		io completed cause of c	Bish	WY W	Jalsh	Rd C	umberle	and M	10219	502
į	Sta Registr	te ar	31. Date filed (Mon		32. Registr	rar's Signature	bark	1	05532 Rd (				

State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15 2009 11:50 A M April Betty Jane Violet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Williamsport Homewood at Williamsport Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 N F 215-18-2428 19.1923 Director 85 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylan h and Mental Hygiene. rise marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examinat must be notified at 1 ☐ Yes 2 🔯 No Director Maryland Washington County Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 U.S.A. 16505 Virginia Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: ģ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Mfg. Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy B. Horst Mary Catherine Glesner Horst ပ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any Injury or other traur Terrie Josephs-niece 18809 Preston Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-16-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examir The law requires that the death certificate be executed the burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician of for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 1 TYes 2 11 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending ↑ Natural 2 Accident 5 Pending after death.

Director: At d in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only опе) 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number 30. Name and address of WH-12 32. Registrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	ate of Maryland	-	artment of F r <i>tificate of</i>			jiene eg. No. 20	09	13651
	Physici	an	Decedent's Name (First, Middle, Last)	Paul WEISE	RUBU			2. Date of Dear		Year	3. Time of Death 1:00 P M
	/Medic	al	4a. Facility Name (If not institution, give stree		JOND		r Location of Death	Vhi i i i	4c. County	of Death	
	Funeral		Suburban Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. le	ast birthday)	Bethes If Under 1 Year		8. Date of Birth	Mont	9. Birthi	place (State or Foreign
	Director		577-18-6663	2□F 88	Yrs.	Months Days	Hours Min.	8. Date of Birth OCt. 16	, Year) 920	Was	hington, DC
	ryland thow		10a. State 10b. County		, Town or Lo					1	10d. Inside City Limits
	the Ma 28a-f s	recto	Maryland Prince Geor	ges	Col	lege Park	<u> </u>	1	0g. Citizen of W	hat Cou	1 ☐ Yes 2 No
	th with 23a or ust be	ral Di	4705 Fordham Road			101. Zip 0000	20740	I	United		-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Evamine: must be notified at once.	by Funeral Director	1)√ Never Married 2 Married 1	/as Decedent Ever in U.S rmed Forces? ☐Yes 2☐No Yes, Give ear or Dates:		Was Decedent of H fYes, specify Cuba I □Yes 2 No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify.	k, White,	can Indian, etc. ite
15-0	in 72 ho "natu	Completed by	15. Decedent's Education (Specify only highest grade con	npleted)	16a. Deced (Give life, L	dent's Usual Occup kind of work done OO NOT use retired	oation during most of worki d)	ing	16b. Kind of Bu Interna		
1212	ed with lygiene ner than			ollege (1-4or 5+)		estigator			Service		
land	ild be fil fental H <b>'ked otl</b> ic even	To Be	17. Father's Name (First, Middle, Last)  Louis We	eisbord			18. Mother's Name	illler	Maiden Surnam	9)	
Baltimore, Maryland 21215-0036	2 shound In and In and In Insurant		19a. Informant's Name/Relationship (Type. F			•	and Number or Rura				
ē, P	s 1 and if Health item 27 other t		Heidi Granzow, Niece 20a. Method of Disposition	20b. Pi		Fordham sition (Name of place of place)	Road, Col		rk, MD 20c. Location -	2076 City or To	
ti m	. Page tment c tant: If		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	variioni State	Lebano	on Cemete	ry 104/13		_Adelph	i, M	D
Bal	permit Depar Impor any In		21. Signature of rune al Service Lin	3			⁵°feb⊮ew F 1 St., NW			חר	20012
			23a. Part F. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death use on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Shock				_	Onset and Death
	Examiner		Sequentially list conditions. b.	и	LIOU	y trac	+ infe	chan			
Eh	uted	Examiner	Sequentially list conditions, if any reading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a sonsequ	ence of).						
7 P.	ifficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):						
207 F 68760,		<b>ledical</b>	d								-3007
.0. Box	requires that the death certific een signed by the attending p nould be detached for use as t	Physician/M	in the past 12 months?	yes, outcome of pregnar □ Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3 [	Ectopic pregnance Other (specify) _	y		23d. Date Mor		ery Day Year
1/10/ S, P.	ires that the de signed by the a d be detached to	by Ph	Part II. Other significant conditions contribu	ting to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.				he cause of death?
2 prop	0 +	eted						1 □ Ye			bably 4  Unknown
و ا	The la ate has	Completed						autops perforr	sy p njedd? d	rior to co eath?	ompletion of cause of
PHUL Vital F	sicien: Th cer lificate irector, pag	Be	25. Was case referred to medical examiner?	ial:		. a 🗆 Double of the	26. Place of Death	(Check only on	e)		~
/ =	ding Phys h. After this funeral dir	on: To	1 les 2010	1 Inpatient 2 L	ER/Outpatien 28b. Time of Injury	t 3 ∐ DOA   28c. Injur	er: 4 □ Nursing Hor y at :	me 5 ☐ Reside 28d. Describe ho			<u>(b)</u>
SBORD Division o	or Attending Physicien: after death. Director: After this cerlifical I in by the funeral director, I	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28	Be. Place of Injury - At hor		M 1 🗆	Yes 2 □ No	28f. Location (St	treet and Numbe	er or Run	al Route Number,
SS	i gige		4 Homicide determined	building, etc. (Specify	")			City or Towi			
豆	Ho 24 P Ful stely	ledical	29a. Certifier (Check only one) 1 CertifyIng Physicia 2 Medical Examiner:								
3	To the within ?	Me	29b. Signature and title of certifier	0 1 177		29c. Licens	e number	2	9d. Date signed	(Month,	Day, Year)
	1215		30. Name and address of person who complete		23a) (Tvne	Print)	54 40	5	4110	130	507
(12			30. Name and address of person who comple M.L. Means, M.D.,	1 00 (0) 11 1 01 1			Bethesda	, MD 2	0814		
	Sta Registr		31. Date filed (Month; Day, Year)  APR 14 2009	De Leva A	. pa	Med					

Baltimore, Maryland 21215-0036

# and

Box 68760, attending physician Division of Vital Records, P.O. After this

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:57 PM 15, 2009 Margaret Wilson April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland
If Under 1 Year | If Under 24 Hrs. Devlin Manor Health Care Center <u>Allegany</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Hours Months Days Min. 1 □ M 2 🕅 F Yrs. 91 170-12-8590 **Director** 07/17/1917 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD ALlegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11801 Bedford Road, NE 21502 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, It a Marical Examinar must any injury or other traumatic event, It a Marical Examinar must once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 □Yes 21 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Smith Hattie Ruth ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kay Robinette / Niece 840 Michigan Avenue, Cumberland, MD 21502 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State 04/18/2009 Rainsburg MPU Cem. Rainsburg, PA 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral/Service Ligensee P.A. 404 Decatur Street, Cumberland, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 1 ☐Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊟Natural 5 Pending 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier t - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cepn 16, 260 8 D0017565 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRS L2U21e ND 21502 Boll ino Netl 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Please	State of Marylar						Лe.	
	-	For State Registrar	State of Marylar		artment of n tificate of D			eg. No. 20	09	13653
		1-Decedent's Name (First, Middle, Last	)		1		2. Date of Dea		Year_	3. Time of Death
Physicia /Medic		Kosina		W	ampler		April	13 2	009	11:40 AM
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		eath	4c. County o	of Death	
		The Johns Hopkins Ho		. last birthday)	Baltimore If Under 1 Year	City If Under 24	Hrs. 8. Date of Birth		9. Birtho	lace (State or Foreign
Funeral Director		5. Social Security Number 6. Security Number 1	M 2 K F 7. Age (in yrs	Yrs.	Months Days		Min. (Month, Day, December	Year)	Countr Mary	lace (State or Foreign ry) yland
		Usual Residence of Decedent							11	0d. Inside City Limits
arylar show d at	ž	10a. State 10b. County	_	ity, Town or Lo rostburg	cation				"	1 ☐ Yes 2 No
the M 28a-f lotifie	Director	Maryland Allegar  10e. Street and Number 16813 La	partown Road, S.W		10f. Zip-Code		1	0g. Citizen of W	hat Count	try?
If Z 12 15-UU30 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		10013 LA	Dartown Roda, D. W	•	21532-			U.S.A.		
ems ser mus	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		- America k, White, e	
s after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify.	Whit	te
3-UU30 72 hours aft natural", or		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	fwarking	16b. Kind of Bu		
hin 72 Ban "na Medio	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	DO NOT use retired)	) )	r working	homemal	ret.	
ed with year that the	Completed	12 17. Father's Name (First, Middle, Last)	0	поше	rmaker	18 Mother's	s Name (First, Middle,			
	Be	Charles Atkinson					Bessie Wilson		-,	
Taryian 2 should be and Mental is marked c	၉	19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address (Street a	and Number	or Rural Route Numbe	er, City or Town,	State, Zip	
E, MC 1 and 2 : Health ar tem 27 is		John C. Wampler	husband	16813	3 Loartown Ro	ad, S.W	Frostburg	Mary	land	21532-
baltimore, permit. Pages 1 an Department of Heat Important: If item 2 any injury or other		20a. Method of Disposition		Place of Disponentery, cre	osition (Name of matory or other plac	e)	Date	20c. Location -	-	
Saltimor bermit. Pages Department of Important: If it any injury or once.		4 Donation 5 Other (Specify	)		Memorial Parl		April 17, 2009	Frostburg	M	aryland
Departition of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co		21. Signature of Funeral Service Licent	Quest	2	2. Name and Addres  Durst Funer	-	, 57 Frost Ave.,	Frostburg.	MD :	21532
		23a 11. Enter the disease, or comp	olications that caused the dea	ath. Do not en						Approximate Interval Between
Physician	0.7	shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Sesis						1	Onset and Death
/Medical		resulting in death)	Due to (or as a conse	equence of):						
Examiner	7	Sequentially list conditions,	b					17	_	
ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):						
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e be exisician	ical		d	·						
box bb/red beath certificate be attending physical for use as the	Physician/Medi	IF FEMALE:								
BOX eath cer attendir	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Dat Mor	e of deliventh	ery Day Year
	ysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	dealii 5	Other (spechy)					
requires that the een signed by the hould be detach	by Pr	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause gi	ven in Part I.	23e. Did to		ribute to t	he cause of death?
ecords, aw requires the been signe							1 🗆 1	res 2 No	3 Prob	pably 4 Unknown
O & O	Completed						24a. Was a autop	sy	prior to co	ppsy findings available empletion of cause of
The	Con						1 🗌 Yes	2 No	death? 1  Yes	2 × No
VITAL   slcian: Th certificate irector, pa	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 XInpatient 2	☐ ER/Outpatie	ot 3 DOA Oth	0.00	f Death (Check only or ing Home $5 \square$ Resid		or /Specifi	
Phys this gral d	5 ::	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injur	y at		now injury occur		y/
OIVISION or Attending I after death. Director: After In by the fune	ertification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	Yes 2 □ No				
5 5 5 5 5	tific	3 Suicide 6 Could not b	28e. Place of injury - At building, etc. (Spec		reet, factory, office		28f. Location (: City or Tow	Street and Numb n, State)	er or Rura	al Route Number,
DIVISI Hospital or Attent 24 hours after deat Funeral Director: stely filled in by the	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my ki	nowledge dea	th occurred at the tir	me date and	place, and due to the	cause(s) and ma	anner as s	stated.
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	(check only one) 2 Medical Exam	niner: On the basis of exami and manner stated.	nation and/or i	nvestigation, in my c	pinion, death	occurred at the time,	date and place,	and due t	to the cause(s)
o the vithin to the comple	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	1 (Month,	Day, Year)
8		haten	$\mathcal{O}$		RE	5-000		April 1	3, 2	2009
		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	e, Print)	-	200 No-de 141-	Ifo Ct. Do	lei en e	MD 21227
YLS		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		- 6	NORTH WO	ine St, Ba	iumoi	re, MD, 21287
Sta Regist	ate rar	APR 15 2009	<i>y</i>	bare	lad .					
DHMH 17 Pay 1/2		41 N 4 0 2003	Marina G.	1 June						

09-02887 George Richard Wolf

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 1365	2	0	0	9			3	6	5	
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Amended, #1	0 <del>4</del> -	For State TCF	ID 04/1	1/1/2000	TIC	Certif	ficate of	Death					eg. No.		3. Time of Death	
Physician	n/ 1	. Decedent's Name	e (First, Midd	le,Last)	<del>,</del>							Date of Deal Month April 10, 2		Year	1843 hrs	
Med: ેવી Examin																
		a. Facility Name (1 2946 Green			and number /			Cambrid						chester		
Funeral		5. Social Security N	lumber	6. Sex	7. Age	(In yrs. last	birthday)	If Under 1		If Under 2	0.4im			(	Birthplace (State or Foreign Country)	
Director		169-28-3	3746	1 <b>XX</b> _M 2	F	73	Yrs.	Months	Days	Hours	Min.	MARCH	20,	1936	PA	
	t	Jsual Residence o	f Decedent								10d. Inside City Limits					
* any		10a. State	10b. County				own or Location	ווכ							1 Yes 2XX No	
land -f sho	į.	MD	TALB				ADION	10f. Zip Co	ode			1	0g. Citizer	of What C	ountry?	
: Mary or 28a	Director	8515 DE				on Cor	vo Dd	21	601			ŀ		USA		
		11. Marital Status	SP GOV		as Decedent		13. Was	Decedent	of Hispa	anic Origin	n? (Speci	ify Yes or No	0- 14		nerican Indian, Black,	
eath v	Funeral		ed 2 XX		rmed Forces?  Yes 2	No		es, specify (	_		Puerto Ric	Jan, etc./				
after d	by F	3 Widowed		ivorced If Yes, I	Give Year		1 16a. Deceden	Yes XX			nd of wor	k done		ecify: d of Busine	WHITE ss/Industry	
nours a		15. Decedent's E					16a. Deceden during m	rs usual Od ost of worki	ng life. [	OO NOT u	se retired	i)	100.14.1	0.200	,	
36 in 72 l	Completed	Elementary/Sec	ondary (0-12	()	ollege (1-4 or	3+)	SALESI	PERSON	ī				PRINT	ER		
5-0036 iled within 77 Hygiene. I other than	튅	17. Father's Name	(First, Middle	e, Last)					18	8.Mother's	Name (F	irst, Middle,	Maiden St	ırname)		
215 be filed ntal Hy rked of	Be	GEORGE	S. WOL	F						ETH	EL HC	AHLLL	N		tate 7in Code	
21; ould b d Men s mar	리	19a. Informant's N	ame/Relation	nship (Type, Pr	rint )										itate, Zip Code)	
MD nd 2 sho alth and m 27 is		NANCY W		IFE		20b. Pl	8515_ lace of Dispos	DEEP sition (Name	COV of cem	E RD netery,	EAS	Date	20c. Lo	cation - Cit	y or Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-0	1 XXurial 2		on 3 Re	moval from St	ate cr	ematory or ot	her place)			ANDIT	1.0	2000	17 4	CTON MD	
imc Page ment tant:		4 Donation 21. Signature of F	5 Other	Specify:		WOO	DLAWN 22.1	l-me and f	ddrocc	of Eacility		16,			ASTON, MD	
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	-11		~	00 E 0	2550	$\sim$	200	JŠ. "H <i>i</i>	RRI	SON	ŠT. E	& NEW ASTON	NAM I I, MD	UNERA 21601	L HOME, P.A.	
Physician		23a. Part I. Enter	the disease,	or complication	ns that caused	the death.	Do not enter t	he mode of	dying, s	such as ca	ardiac or r	respiratory a	rrest, shoc	k, or heart	Approximate Interval Between Onset and	
Medical.		failure. List o		se on each line se a. Guns	∍. shot Woun	d of Neck	k								Death	
caminer		or condition resul		Due to	o (or as a cons	sequence of	):									
	_	Sequentially list of if any, leading to	conditions,	b	o (or as a cons	sequence of	):									
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ed isit	Examine	events resulting			o (or as a cons	sequence of	):									
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To with To con	Med	29b. Signature	and title of ce		marrier state	-		29		ise numbe	er		- 1		d (Month, Day, Year)	
		1/ / /	rlo	Rein	0				0.0	.M.E.			Apı	ril 11, 20	U9 	
TLS		30. Name and a		rson who com	pleted cause of	of death (Iter	m 23a)	C4	+ Dali	imer-	MD 242	201				
61 VA		Laron Lo			Medical E			nn Stree	ı, bait	miore, i	VIU 2 12					
Regi	Stat		APR.	1°4 2009	Sz. Regis	strar's Signa	B. A	and								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 4:00 8, Αм April Dorothy Regina Wright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner 6526 Greenmount Drive Howard Elkridge 8. Date of Birth (Month, Day, Y [arch 12, 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F 81 March 1928 Maryland Director 578-34-5938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pagement of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 1.2.000.

900. 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 XYes 2 □ No Director Maryland Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21075 6526 Greenmount Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ₫ 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Rosalia Lorenz John Paul Dell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Ann Weaver/ Daughter 9631 Boyds Turn Road Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland

Voternal Computers Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/15/2009 | Cheltenham, MD Veteran Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Ferral Service Lig 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE WO 1) BMin DA years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner precuring Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Du to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 Ves 2 Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 S autopsy page certificate 2 No 1 TYes 2 🗆 No 1 □ Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner Other: 4□ Nursing Home 5□ Residence 6 MOther (Specify)Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation To the within 24 hours after ucc...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 200 2061) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIUMBA 31. Date filed (Month, Day, Y Mu 11055 Registrar's Signatu State Registrar

09-03133	
Tobi Laray Wills	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	O Iviai ylailu /	Certifica			ia Meritari		eg. No.	200	9 1365
	Physici		Decedent's Name (First, Middle,La	st)				-	Date of Deat     Month		Year	3. Time of Death
vie	dical Exami	ner	Tobi Laray Will	S					Month April 19, 2			1240 hrs
			4a. Facility Name (if not institution, girling Civista Medical Center	ve street and number)		4	•	r Location of Dea	th	1	unty of Death	
	F-			1=	<del></del>		LaPlata			Char		
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birt	hday)	If Under 1 Year Months Day			th (MM/DD/\	Foreia	hplace (State or n
	Director		213-90-4545	M 2XF	33	3 Yrs.	Wioritins Day	75 110015 101	04/15/	1976	Col	untry) DC
	ž,		Usual Residence of Decedent  10a. State 10b. County									
	ow any		10a. State 10b. County	111	Dc. City, Town	or Locatio	on					10d. Inside City Limits
	Maryland 28a-f show 1 at once.	to	MD Charles		Waldor	E						1 X Yes 2 No
	Mary r 28a ed at	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen o	of What Cour	itry?
0	ith the Maryland 23a or 28a-f sho notified at once.		6086 Thoroughbre	d Ct. #D			20601			USA		
	death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent E	ver in U.S.			spanic Origin? ( \$ n, Mexican, Puerl	Specify Yes or No-		Race - Americ	can Indian, Black,
	r dea or it	ᆵ		1 Yes 2	No				3 1 110011, 01017		rrinto, otc.	
	0036 within 72 hours after giene. rer than "natural", c	þ		If Yes, Give Year or Dates:			Yes 2 X No				cify: Bla	
	hour "natu	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+				ition (Give kind of b. DO NOT use re		16b. Kind	of Business/I	ndustry
	36 nin 72 Ihan dical	릛	Elementary/occordary (0-12)			a + am	om Com***	ioo Dom				
	d with	ě	17. Father's Name (First, Middle, Last	l year	- Lu	SLOM	er serv	ice Rep.	ne (First, Middle, N	Valu	e City	7
	21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exami	Be	Cornell R. Wills						oppedge	naiden ourn	iame _/	
		To	19a. Informant's Name/Relationship (		196	. Mailing	Address (Stre	et and Number or	Rural Route Num	ber, City or	Town, State.	Zip Code)
	e, MD 1 and 2 sho Health and item 27 is		Clara Wills/moth	er	Ī				n, MD 20			-,,
	imore, MD 2 Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	- 1	20a. Method of Disposition		20b. Place o	f Disposit	ion (Name of ce		Date	20c. Loca	tion - City or	Town, State
	nor ages ant of tt: If		1 X Burial 2 Cremation 3			ory or oth		, ,	05/0000			100
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	/Medical		failure. List only one cause on e  Immediate Cause (Final disease a	III and a section	sive ca	ardio	vascula	ar disea:	se			Between Onset and Death
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		L	Sequentially list conditions, b.									
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED	AMENDED 23a,	PII,27	,perM	IE, g891	5/14/09	TT			
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	68 certification	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Feta	al death 3	Ectopic pregr	ancy	Mon	th D	ay Year
	Box 687 he death certific	Physician	1 Yes 2 No 9 V Unknown	Pregnant at tin	ne of death 5	Oth	er (Specify)					
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	law re	휠							autop:	sy		ompletion of cause of
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	J of Jing Pl After funera	崩	27. Manner of Death  1 X Natural See Deading	28a. Date of Injury (Month, Day, Year	28b. T	ime of Inj	·   -	ry at Work?	28d. Describe h	ow injury o	ccurred	
	ivision or Attencather death Director:	훓	Pending  Accident Investigati	on				Yes 2 No				
	Division pital or Attendio ours after death. teral Director: A	Certification:	3 Suicide 6 Could not determine		y - At home, fai	rm, street	, factory, office t	building, etc.	28f. Location (S or Town, St		umber or Rur	al Route Number, City
	Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ē	4 Homicide	(opcony)	/							1
	To the Hos within 24 h To the Fun completely	ca	(Check only Certifying Physic	ian: To the best of my ki :On the basis of examin	nowledge, dea	th occurre	ed at the time, do	ate and place, an	d due to the cause	e(s) and ma	nner as state	d.
	To t To t	Medical	29b. Signature and title of certifier	and manner stated.	adon and/or III	yall			a. a.c unic, uate à			
		-	200. Signature and title of certifier	6 00			29c. Licens				•	th, Day, Year)
	2	L	MINI UL	W (V)			0.C.	IVI.⊏.		April 20	, 2009	
-	BI		30. Name and address of person who Russell Alexander MD.		,	444	Donn Ct	Dolti	ID 04004			
				Assistant Medical  32. Regultrar's		1111	emi Street,	Baltimore, N	10 2 120 T			
	Regist	ate rar	APH 2 3 2009 (ar)	م الله	Jak.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month APRIL 2009 WIT.I.IIW J. WADE 10:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 5912 PLATA STREET CLINTON 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day OCT • 11 9. Birthplace (State or Foreign 6. Sex 1957 Months Days Hours Min. 1 √ M 2 □ F WASHINGTON, DC 51 579-78-9221 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 Yes 2 □ No Director PRINCE GEORGE'S CLINTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 USA 5912 PLATA STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH BUS DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES WALTER WADE VTRGTNTA THOMAS ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FELECIA L. WADE/WIFE 5912 PLATA STREET CLINTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 4/18/2009 SUITLAND, MARYLAND Signature of Fun ral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eymonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>2</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 210 No 1 ☐ Yes 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1∏Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. of Vital Records, **Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Widesi Evair in a true the netified at once.

**Physician** /Medical

Examiner

sician and burial-transit

attending physician for use as the buria

signed by the ad be detached for

cate has been si page 2 should t

certificate

detached

Baltimore, Maryland 21215-0036

The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Division Hospital or Attending

State Registrar

1 5 2009

29b, Signature and title of certifier

29a. Certifier

Medical

SYLVESTER OKONKWO M.D. 6192 OXONHILL ROAD # 507 OXONHILL, MARYLAND 20745 32. Registrar's Signature

20100110WO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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	11013	st State of Maryland / Departme	ent of Health and Mental F	łygiene						
			ate of Death	Reg. No. 20	19   365					
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year  April 16, 2009	3. Time of Death 0735 hrs					
redical Exami	_	William Cooper Whitehurst  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		th					
)		Frederick Memorial Hospital	Frederick	Frederick						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth X M 2 F	hday) If Under 1 Year If Under 24H  Manths 2 9 Hours Mi	Fore						
ny	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits					
how a	_	MD Frederick Brunsv	wick		1 XYes 2 No					
larylar 8a-f s at on	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?					
the M is or 2 utified		47 East B Street	21716	U.S.A.						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		erican Indian, Black,					
s after ral", o	à	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind o		hite					
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36 hin 72 e. than	ple	0	N/A	N/A						
5-00 ed wit fygien other he Ma	S	17. Father's Name (First, Middle, Last)	18.Mother's Nar	me (First, Middle, Maiden Surname)						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	a	Wilmer David Hutting Jr.	Susan	Brantley White	hurst Osbo					
D 21 should and Me is ma atic ev	-1		b. Mailing Address (Street and Number of							
, MD and 2 sho salth and em 27 is			an B. W. Osborne- Mom 47 E. B St. Brunswick, Maryland							
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Baltimore, bermit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify H11. 21. Signature of Funeral Service License:	1 sboro 2	2, 2009 Hillsbo oudoun Funeral	ro, VA					
Bal permi Depa finipo		Lionard Villani	158 Catoctin C	r. SE Leesburg,	VA 20175					
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- /Medical xaminer		failure. List only one cause on each line. <b>Enterobacter</b> Immediate Cause (Final disease or condition resulting in death)  a. congenital heart Due to (or as a consequence of):	cloacae bacteremia : disease	complicating	Death					
	_	Sequentially list conditions, b.								
	xaminer	if any, leading to immediate cause. Enter Underlying Cause C.  Due to (or as a consequence of):								
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - trans	calE	X UNPENDED AMENDED 23a, 27, pe	erME, g894 8/10/09	rT						
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of Vital Records, ag Physician: The law require After this certificate has been si meral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/C	Othor		her:					
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ion tendir eath or: A the fu	tion	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No							
Division of Vital Records, P.O. Box 68760, et lospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  The law requires that the death certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 Could not be determined (Specify)	arm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, Cit					

Registrar

State 31. Date filed (Month, Day, Year)

30. Name and address of person who complete dause of death (Item 23a)

Theodore M. King, Jr., MD.

32. Registrar's Signature ORIGINAL

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

April 17, 2009

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar  1. Decedent's Name (First, Midd)	lo Last)	Ce	ertificate of			eg. No. 2 ()	09 13659 3. Time of Death
	Physici /Medic		WILLIAM LEO		S SR.			Month APRIL		Year
1 3	Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of	
*		e ^d wa	CHARLOTTE HAD 5. Social Security Number				OTTE HA	8. Date of Birth	ST.	MARY'S
E Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Cons	Funeral Director		219-16-0248 Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. last birthday 84 Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	9. Birthplace (State or Foreign Country) WASHINGTON, D
Maryland	f show led at	tor	10a. State 10b. County  MD CHAR		10c. City, Town or L					10d. Inside City Limits  1XX es 2 ☐ No
with the	a or 28a t be notif	Director	10e. Street and Number 307 FREDERIO		I DA FDA	10f. Zip Code 2064	6	1	0g. Citizen of W	
<b>-0036</b> hours after death with the Maryland	plene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married XX Mar	12. Was Deceder Armed Forces rried 17 Yes 2	] No	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		- American Indian, K, White, etc.
003 ours a	ıral", o Exan	d by	3 ☐ Widowed 4 ☐ Divorced	d Yes, Give Year or Dates	43-146	1 ☐ Yes XXNo			Specify:	WHITE
21215-0036 ed within 72 hours af	ne. nan "natu e Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4o	r 5+) (Giv life.	edent's Usua! Occup e kind of work done DO NOT use retire	oation during most of work d)	king	16b. Kind of Bus	siness/Industry
d 21	ntal Hygie ed other tl event, th		1.2 17. Father's Name (First, Middle	, Last)	_MAN	IAGER	18. Mother's Nam	ne (First, Middle, I		E STATION
Maryland	و ۾ ڇ	To Be	WILLIAM OS	WALD YATES				NAOMI		•
lary 2 shou	and Menta is marked aumatic ev		19a, Informant's Name/Relations	ship (Type. Print)	19b. Mai	ing Address (Street				
	if Health and Mer Item 27 is marke other traumatic		H. ANN YATES	S / WIFE	30.7	FREDER I	CK DRIVE	E LA PL	ATA, MI	D 20646
	0		Murial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	SACRED	HEART C	EM. 4-2	4-09	LA PLA	TA, MARYLAND
Bal	Department Important: i any injury o		21. Signature of Funeral Service	Lioensee C5	M00641 5	22. Name and Addre	ess of Facility RA HINGTON	AYMOND AVE.,	FUNL.S. LA PLA	ERVICE, P.A. TA, MD 20646
e etc			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caus t only one cause on each	ed the death. Do not el line.	nter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
/N	ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)		ACCARCI as a consequence of):	NOMA	OF L	UNG		onot una boun
	ister .	ner	Sequentially list conditions, it any, leaving to immodiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or s	te a consequence of):					
, xecute	and al-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):					
: <b>68760,</b> rtificate be executed	ig physician and as the burial-transit	Medical E		d						
× 8	uttendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (s <i>pecify</i> ) _	у		23d. Date Mon	e of delivery th Day Year
	signed by the a lld be detached f	þ	Part II. Other significant condit		but not resulting in the		ven in Part I.	23e. Did tol	1	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Division or Vital Records, for Attending Physician: The law requires t	ate has been si page 2 should b	Completed	CORONARY	ARTERY	DISEASE			24a. Was a autops perform	med? pi	Vere autopsy findings available fior to completion of cause of eath?  ☐ Yes 2☐ No
/ital	is certificate director, pag	Be C	25. Was case referred to medica examiner?					th (Check only on		
Or /	this all dir	은	1 ☐ Yes 2 ☐ Ho  27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of Ir	tient 2 ER/Outpatie	III 3 DOA		ome 5 Reside		
Vision or Vita	m. : After e funer	tion	Vatural 5 ☐ Pendi		Day Year)   Injury	Wor	ryat rk? ]Yes 2 □ No	28d. Describe ho	ow injury occurre	ed
Divisi	within 24 hours after deart  To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	ningd   Zoe. Flace of I	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Si City or Town		er or Rural Route Number,
Div	r 24 nours le Funera letely fille	Medical C		ng Physician: To the bes I Examiner: On the basis and manner	of examination and/or i					
Toth	within 24	Me	29b. Signature and title of certific	m MD	)	29c, Licens	se number	2	-	(Month, Day, Year)
			30. Name and address of person	who completed cause of	death (Item 23a) (Type 14090 HG T		., St. 23	300, Solo		
	Sta Registr		31. Date filed (Month, Day, Year		strar's Signature	house			. <u> </u>	
DHMH 1	17 Rev 1/2	001	71 (	C EUU C	The same	your				

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month F. Constance Albert 4 2117 PM 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 edale Baltimore FRANKLIN Square Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 ☐ M 2 ☐ F Months Days Hours Min. 215-10-7987 May 9, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6808 Crossway 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 X No If Yes, Give Year or Dates: Specify: à Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Farino Angelina Qurico 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Briggs Daughter 6810 Crossway, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April at 30. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem. Baltimore, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final infarction myocardial disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death), act Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Bladder Cancer, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed arterial fibrillation Hyperlipidaemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑No 2 □ No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide

as attending properties for use as Ö σ. Division of Vital Records,

physician and s the burial-trans the funeral dir this

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at

**Physician** 

/Medical

Examiner

land 21215-0036

Baltimore, Mary

or Attending after death. filled in by 24 hours a Hospital сотріетел within 2

Registrar

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RES 0000

29d. Date signed (Month, Day, Year) 261 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR ADEDOYIN & AKINTIDE 9000 FRANKLIN SQUARE DR BALTO Md 21237

31. Date filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0^{Year} Allen 04 7:29a.M Anna 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Randallstown 9706 Southall Road Apt If Under 1 Year | If Under 24 Hrs. | Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days Months 1 ☐ M 2**X** F 216-42-3914 66 15 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Baltimore Randallstown MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21133 9706 Southall Road Apt 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry United Cerebral 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Palsy Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elva Binford William Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7530 Haystack Drive, Windsor Mill, Md 21244 Byron Allen-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/28/09 Woodlawn, March Wast March Wast 4300 Wabash Ave, 21. Signature of Funeral Service Licenses Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INFARCTION MYOCARDIAL disease or condition resulting in death) Due to (or as a consequence of): TERY STENOSIS seque it ally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOMYOPATHY (ISCHEMIC 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 X 1 ☐ Yes 25 Was case referred to medical

**Physician** /Medical Examiner

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Important: If Item 27 is
any injury or other trau

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine attending physiclan and for use as the burial-tran Physician/Medical for use signed by the a d be detached for 2 Completed cate has t page 2 s Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,-X

the

	25. Was case reletted to filedical	26. Place of Di	eath (Check only one)
	examiner? 1∐Yes 2MNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 Residence 6 □Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ì	29a, Certifier 1X Certifying P	vsician: To the best of my knowledge, death occurred at the time, date and pla	ce, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27157 APRIL, 27 2009

30. Name and address of person w completed cause of death (Item 23a) (Type, Print)

3100 LORD BALTIMORE DR. #110 BALTIMORE, MP21244 DEPESTRE RAYNOLD 31. Date filed (Month, Day, Year)

State Registrar

Medical

**APR 29** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20091 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 5:06 PM Anderson 2009 April 70 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Çity, Town, or Location of Death **Examiner** Baltimore Mospital of Baltimore Sette of Birth (Month, Day, Year) 948 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
 Country) **Funeral** Months Hours Min 1 M 2 □ F Yrs. Director toril 22, Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Modical Examinar is ust be notlined at **Funeral Director** 1 Yes 2 □ No saltimore 10e. Street and Numbe 10g, Citizen of What Country 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No <u>ک</u> Specify: Specify: Blac 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GED 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 5 Department of Important: If it any Injury or concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on concept on 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Eacility
Joseph L. Rus
ZZZZ W. Nor 21. SignatOre of Funeral Service Licensee 23a. Par 1 Enter the dilease, or complications that cause i the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship, or heart foliume. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal bleed. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner iver circhosi. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a, Was an 2 No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 24, 2009 CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Braner, MD Sivai 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 29 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Martin **Physician** Askin 18:31 2009 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland Medical Center Baltimore N/A 20 University If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 12/20/1942 Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location t0a State 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Wedical Examination mat be notified at Director 1 □Yes 2 Y No MD HOWARD COLUMBIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 6830 CARAVAN COURT 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mydicone. (Give kind of work done during most of working life. DO NOT use retired) MATERIALS HANDLING Elementary/Secondary (0-12) College (1-4or 5+) CONSULTANT OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JULIUS ASKIN ပ CATHERINE **NELSON** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL ASKIN/WIFE <u>6830 CARAVAN COURT, COLUMBIA, MD 21044</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 04/28/2009 COLUMBIA, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kecurrent **Physician** Lymphom 9 disease or condition resulting in death) ) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed sician and burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Vunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 □Yes 2 No Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU4176435 Z18194 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP Zan Zaidi Greene St Baltimore 31. Date filed (Month, Day, Year) State APR 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** A M 28, Barna April 7:30 Gloria /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care - Rossville Rosedale 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 1 □ M 2 🛛 F June 63 218-44-6249 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evandrate must be notified at once. 10a State 10h County 1 ☐ Yes 2 ☐ No Dundalk Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 2902 Dunran Road Apt D Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: à 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank of America Janitorial Worker 7 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lottie Wujek Edward Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2510 Sycamore Avenue, Sparrows Point, Md. 21219 son Frank Barna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April Date 29. 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bayview Crematory 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. the m 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO VASELLAR DISEASE Physician THEROSCURIOTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and stransit the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be det Division of Vital Records, ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PERPARATHYROIDISM Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 🗔 🛪 o 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number nd title of certifier 29b. Signature a

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person.

31. Date filed (Month, Day, Year)

L467521021

PANKA

completed cause of death (Item 23a) (Type, Print)

32. Refistrar's Signature

D0060560

9106, PALLADELPHIA RA. #208, BALTIMORE, IND

APRIL 28,2009

	1 - State of Ma	ryland / Depa <i>Cer</i>	rtment of H tificate of D			giene Reg. No. 2000	9 13665
nysician Medical	1. Decedent's Name (First, Middle, Last)  JOSEPH	BLOO	M :	TR	2. Date of Dea Month APRIL	th Day Year 27 200	3. Time of Death 6 05:02 P M
xaminer neral	4a. Facility Name (If not institution, give street and number)  TOHNS HOPKINS BAYVIEW M  5. Social Security Number  214-50-8910  6. Sex 150 M 2 F	EDIXAL CENTER (In yrs. last birthday) 59 Yrs.	4b. City, Town, or BALT I		8. Date of Birtl (Month, Day	4c. County of Dea N/A  N/A  (Year) 9. Bir  Co	
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loo			NOV. O	0 1949	10d. Inside City Limits 1 □ Yes 2 ☑ No
important, intentions intentional transfer of the Modeal Exportment and Injury or other traumatic event, the Modeal Exportment near the profile at once.  To Be Completed by Funeral Director	Maryland   Anne Arundel   10e. Street and Number   7798 Cypress Landing Road		Set 10f. Zip Code	vern 21144		10g. Citizen of What Co	
exponent ount	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Hyes 2 N If Yes, Give	0	Vas Decedent of His Yes, specify Cubar □Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
event, the Medical Ex Be Completed to	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-				16b. Kind of Business/Industry		
atic event, the To Be Co	12   I 17. Father's Name (First, Middle, Last) Joseph Bloom	Owner/Operator  18. Mother's Name (First, Midd  Frances			Tire Company  Te, Maiden Surname)  Wilhite		
er traumat	19a. Informant's Name/Relationship (Type. Print) Mary C. Bloom (spouse)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 7798 Cypress Landing Road, Severn, MD						
in i	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Maryland Veterans Cem 2009  Crownsville						
ouce.	21. Signature of Furgeral Service Lideridee			Mountain	Road, 1	Pasadena, N	Home, P.A. ID 21122 Approximate
ian ical	resulting in death)		HEM ORRH/		or respiratory ar	1651,	Interval Between Onset and Death 5 PAYS
edical Examiner	Sequentially list conditions b. HYTERT	ENSION  consequence of):					5 YEAR S
Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Ye ar
۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the underlying cause given in Part I.					o the cause of death?	
completed by	25. Was case referred to medical					sy prior to death? 2 1 Ye	utopsy findings available completion of cause of
Certification: To Be (	examiner?  1 Yes 2 Mo  27. Manne Death 1 atural 5 Pending 2 Accident investigation  1 Accident investigation	ry 28b. Time of	28c. Injury Work	4 🗀 Nursing no	ome 5 Resid	lence 6 Other (Speciow injury occurred	ecify)
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc				City or Tow		
Medical	29a. Certifier 1	examination and/or inv	estigation, in my op	pinion, death occur	red at the time,	date and place, and du	e to the cause(s)
3	29b. Signature and title of certifier  Pawl R Lci		PES-	number		APRIL 2	
	30. Name and address of person who completed cause of de PAUL R. LEE M.D.	4940 EAS	TERN AV	ENVE B	AUTIM	ORE MD	21224
State egistrar	31. Date filed (Month, Day, Year)  APR 2 9 2009	ar's Signature	1				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 26 2009 8:30 P. M James E. Bryant, Sr. April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Woodstock 10727 Davis Ave. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye April 11 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1**X** M 2□ F 81 220-22-6289 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10a State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, I'm Medical Eventions of the medical events. Woodstock 1 ☐ Yes % 1 No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 United States 10822 Davis Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑Xo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: þ White 3 XVidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Recreation I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) and parks 5th <u>Groundskeeper</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Bryant Vina Livesay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Woodstock, MD 21163 Carole Frizzell daughter 10727 Davis Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State May 2, 2009 Lake View Mem. Park Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Burrier-Oueen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signatur of fur eral Service Licensee ann 1 Call 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. eshitor Im reside Cause (Final dise e or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 22 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 525112 2009 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print)
Tahoora Kawaja 20, Crossroads Drive Suite101 Owings

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ADD 2 9 2009

Down B. Sarke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day April 26 2009 **Physician** Frank Martin Berg 9:00a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4920 Hamilton Avenue Baltimore City Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 17 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Maryland 220 76 6871 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 ☐Yes 2 ☐ No Director Maryland Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4920 Hamilton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 X No Specify: Š White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Johanna Gross Paul John Berg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Arm, Maryland 21057 11630 Glen Arm Road Apt. L 29 Mary Berg (Mother) permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Metro Crematory Inc. April 28 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) anatire of Funeral Serfice Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc Ha 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final ISPONCHAS PARM Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ETZURE DISORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CHIZO AFFECTIVE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 Tyes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial signed by the detack certificate director, within 24 hours a completely

sician and burial-trans

death with the Maryland

72 hours after

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Footlast Examinat must be notified at

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than "

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

YORK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#100

TOWSON

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20091 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:49 PM lanton 26 2009 Jarru 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death UMMC Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-1-1961 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Hours 1**火** M 2□ F Months 212-76-7714 MD 47 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1359 Pentwood Road 21239 A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2 VINO Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/ADisabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John D. Blanton Hattie Bedford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry Blanton-Brother 5307 Leith Road Apt G Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 4-30-09 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue MD 21202 Balto, lade ) ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure LIVEY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown eumonia 2 No 3 Probably 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No Failure 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 Inpatient 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

death certificate be executed Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: Tet hours after death. Funeral Director: After this certifical

Examiner sician and burial-transit attending physician Physician/Medical as the t for use a signed by the a d be detached for 9 cate has been si Completed certificate funeral director, Be Certification: To filled in by the

**Physician** 

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. For 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Madical Examination must be notified at

permit. Pages 1 and 3 Department of Health Important; If item 27 any Injury or other tr. once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner?

6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Street, Baltimore MD 21201. 31. Date filed (Month, Day, Year)

Registrar

cal

29a. Certifier

29



24 hours a

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Age (In yrs. last birthday) Date of Birth Month, Day, **Funeral** Days Director Usual Residence of Decedent 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprince must be notified at Director 1 Yes 2 □ No mor 10f. Zip Code 10g. Citizen of What Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mres 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify \$ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life) DO NOT use retailed

ANAGE Elementary/Secondary (0-12) College (1-4or 5+) Tan 17. Father's Name (First, Middle, L. mmer's Name (First, Middle, M Ten Surname Be ပ Rugal Route Number 2/3/2 Baltimore, 20c, Location - City or Town, State 20a. Method of Disposition 2 Cremation Burial 4 Donation 5 ☐ Other (Specify) av 1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minute /Medical Examiner scale tidly is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (g/ s a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ficate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Records, Division of Vital

> State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day,

30. Name an

29a. Certifier

(Check only one) 29b. Signatu

ause of death (Item 23a) (Type, Print

🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Beckford **Physician** 500 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown vor thwest Baltimore Hospice 5. Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 X F Months Days Hours Min Jamaica **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item I willow I aminer must be notified at once. 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location Baltimore 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number astlemoor Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐Yes 2 No Specify If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Technician 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melaeta Albert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, sline McKenzie Miami, A Southeast Inurd Daugrite 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD Woodlawn 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License aughor C. Orcene Funeral SVS Kandalistown MD 21133 Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory /Medical Due to (or as a consequence of) Examiner ardiopul monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Typotensum Due to (or as a consequence of) the attending physician and burial-tran Division of Vital Records, P.O. Box 68760 Physician/Medical trointestinal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No After this certific funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avenue Sutezos Baltimore MD 21209 Doborah I

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2 9 2009 120000 15. 1900

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1745 PM 200 PRITAM KAUR BAL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSP TAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 💢 F Pakistan 07-01-1944 **Director** 216-15-7057 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evandem trust by notified at 1 ☐ Yes 2 X No Director Fulton MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number India 11364 Duke Street 20759 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 ☐ Yes 2X No Specify: <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) House Wife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be fi Gurbachan K. Randhawa Dayal Singh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar lem 27 ls 11364 Duke Street Fulton, Maryland 20759 Brijinder Singh / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o Pages ō 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Arundel Crematory: 04-29-2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician Trous myo care /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**V** No 2 X No branchiecta 1 □Yes 1 □ Yes Hospital or Attending Physician: 74 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 → npatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2√No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 036845 MD, FCCP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar-Chi hayingh, MD, FCCP grace. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		1	State Registrar		Cei	rtificate of l	Death	R	eg. No. 20	19 136/2
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, La: BEATRICE	T	î	BOLAN	/	2. Date of Deat	Day Y	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv	street and number)		-	r Location of Death		4c. County of	
4			315 Wende Court		(I I - 1 I - 1 I - 1 - 1		n Burnie	O Date of Birth		Arundel  B. Birthplace (State or Foreign
	Funeral Director		220 07 9214		(In yrs. last birthday) 9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) 06/06/	Year) 1919	Country) Maryland
	land ow	- +	Usual Residence of Decedent  10a. State 10b. County	1	I Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	호	Maryland Anne	Arundel	Glen Bu	ırnie				1 ☐ Yes 21 No
	n the	- AT 1-	10e. Street and Number	1		10f. Zip Code		1	0g. Citizen of Wh	at Country?
	th wit	<u>a</u>	315 Wende Court			2	1061		U.S.A	. •
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Notical Evaninar must be notified a once.	by Fui	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12, Was Decedent Ev Armed Forces? 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba 1 □Yes 2 <b>X</b> No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.  White
2-0	72 ho	sted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	oation during most of work	ina	16b. Kind of Busin	ness/Industry
21215-0036	d within 7 giene. er than "r	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 years		retary	during most of work d)	-	Industria	al Laboratories
Maryland	oe file tal Hy d othe	Be (	17. Father's Name (First, Middle, Last,					- (	Maiden Surname)	
yla	Ment Ment arked	၉	Pe	ter Scheele				etta Schi		
Иaг	12 sh h and 7 Is m rraum		19a. Informant's Name/Relationship (			ng Address (Street Horton 1	and Number or Rui			tate, Zip Code) rland 21225
e,	1 and Healt em 2 ther		Henrietta Bond / 20a. Method of Disposition	Niece					20c. Location - Ci	
Baltimore,	Pages ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dispo cemetery, crer Cedar Hi	11 Cemete	ery   05/0	1/2009	Baltimor	e, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Liber	Divlue	22	2. Name and Addre	ess of Facility Go	nce Fune	ral Serv imore, M	ice, P.A. Maryland 21225
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line	Revol	er the mode of dyir	ng, such as cardiac	or respiratory are	cluon	Approximate Interval Between Orset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):		w files	No.	•	
	Examiner	_	Sequentially list conditions	b. — Due to terms			Hyp	ven	wn	year
B.	ecuted and transit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence or):					
68760,69	sertificate be executed ding physician and se as the burial-transit	ical E)	resulting in death) cast	Due to (or as a o	consequence of):					
89	rtifica ing ph as th	Medical	IF FEMALE:							
	Attending Physician: The law requires that the death certificate be executed refeath.  r death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date Mont	of delivery h Day Year
ds, P	iires that signed b d be deta	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	veg in Part I.			oute to the cause of death?  B Probably 4 Unknown
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Division of Vital Records,	:: The law icate has ; page 2 s	Completed			you			autop: perfor	sy pri med? de	or to completion of cause of ath? □Yes 2□No
Vit.	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
of	Phys rthis ral dii	<u>ا:</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	t 2 ER/Outpatier	IT 3 LL DUA	4 □ Nursing H		ence 6 Other ow injury occurred	
ion	ath. r: Afte	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day,	Year) Injury	Wor	rḱ? ]Yes 2 □ No			
Divis	al or Atte s after de il Directo ed in by th	Certification: To	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str ( <i>Specify</i> )	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier Check only one) Certifying Pl	nysician: To the best of niner: On the basis of e and manner state	examination and/or in	h occurred at the ti	ime, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and man date and place, an	ner as stated. nd due to the cause(s)
	To th withir To th comp	Me	29b. Signature and tine of certifier	1		29c. Licens	se number	2	29d. date signed (	(Month, Day, Year)
			HAW / C	Hento	1 cm	1	N438		Mu	28,2009
	5		39. Name and address of person who	completed guse of dea	ath (Item 23a) (Type,	Print)	c- w	11	. 1	2 (112

lumber or Rural Route Number, nd manner as stated. ace, and due to the cause(s) igned (Month, Day, Year) DEFENSE HAHWAY ANNAPOUS MOLIFO,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** AFRIL 27, 2009 11:30A HELEN BICKEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Min. Days Hours 1 □ M 2√□ F Months 1/20/1920 Director 89 MARYLAND 214-12-0897 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its McAlcal Examinations in the notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □ No Director PARKVILLE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1941 EDGEWOOD ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 If Yes, Give 2 **X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 🎇 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BLUE CROSS AND BLUE Elementary/Secondary (0-12) College (1-4or 5+) SHIELD ADMINISTRATOR 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNAVAILABLE CHARLES CANITZ 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1281 GULF OF MEXICO DR. UNIT #502, FL 34228 FRANK PETRALITO/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 4/28/2009 CATONSVILLE, MD Signature of Funeral Service Licensee MOO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) END STAGE HEPATIC FAILURE /Medical Due to (or as a consequence of) **Examiner** PRIMARY BILIARY CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown HEPATORENAL SYNDROME Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? HEPATIC ENCEPHALOPATHY 24a. Was an autopsy performed? Yes 2 No 2 0 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 29c. License number D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7571 OSLER 32. Registrar's Signature DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) State APR 29 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 25 AM **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner RIENDS NURSING Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) September 25, 1919 Washington, D.C. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 💢 F 89 578-24-5564 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2 No Director Maryland Montgomery Sandy Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17350 Quaker Lane 20860 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MX Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Visual Artist/ Farmer Self Employed marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester Garfield Gilbert ပ Alice Mitman and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr. Lynn G. Stansbury / Daughter 220 Warren Avenue, Baltimore, Maryland 21230 April 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servis Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00198 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Adenocarcinoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas performe 2 X No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39793 April 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher J. Mays, M.D. 18111 Prince Philip Drive, Suite 207, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year) APR 29 2009 32. Pegistrar's Signature

park

09-03219 Davi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

id Conway		State of Maryland / Department 1- For State Certificate Registrar			eg. No. 2005	9   367				
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Deat Month	Day Year	3. Time of Death 0815 hrs				
ulcai Examii	rier	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	April 22, 20	4c. County of Death					
¥		710 S. Ponca Street	Baltimore							
Funeral Director		5. Social Security Number 216-32-9398 6. Sex 7. Age (In yrs. last birthday 74	) If Under 1 Year If Under 24Hr  Months Days Hours Mir		a' Transia	thplace (State or gn untry) MD				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	- "		10d. Inside City Limits				
<b>*</b> .	_	MD Baltimor	·e			1 Yes 2 No				
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	ntry?				
th the 1 23a or notifie		710 S. Ponca St	21224		J.S.A.					
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	ican Indian, Black,				
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	17. Father's Name (First, Middle, Last) Nathan Conway		e (First, Middle, M nne Hur						
212 nould b id Meni is marl	To E		iling Address (Street and Number or	Rural Route Num	ber, City or Town, State					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Cremation 3 Removal from State crematory o	r other place)		Beltsvi					
Balti permit. Departri Import		21 Signature of Funeral Service Licensee MOVUUZ 2	2. Name and Address of Facility CA	FA/Step	hen D Lol	nrmann P.A				
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval								
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular [	Disease			Between Onset and Death				
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c 6876 r certifical ending ph use as the	cian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 2 4 Pregnant at time of 5	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery	y Day Year				
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Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner? Hospital: Inpution 2 EP/Output	26.Place of Death (Check							
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To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or investigation.								
X 5 2 2 2	§ e	29b Signature and title of certifier.	29c. License number		29d. Date signed (Mo.	nth, Day, Year)				
7)		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		April 22, 2009					
		Laron Locke MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 212	201						
St Regist	ate trar									
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	_1	For State Registrar			Cer	tificate of L	Death		Reg. No	2009	1367
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3a or	2	1017 Carson Stre	aet			20901			Uni	ted Stat	es
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Hospital or Attending Physician: The law requized hours after death. Funeral Director: After this certificate has been etely filled in by the funeral director, page 2 should include the funeral director. To Be Complete.	cer unication; 10 be	examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigat 3  Suicide 6 Could not determine  4  Homicide Homicide  29a. Certifier 1 Certifying	28a. Date of Inju (Month, Day	ry y, Year) 28b  28b  28c  28c  28c  28c  28c  28c	p. Time of Injury farm, stre	28c. Injun Work M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ar: 4 ☐ Nursing Ho y at :? Yes 2 ☐ No	h (Check only one 5 Res 28d. Describe 28f. Location of City or To	Street a	and Number or Rele) s) and manner a	ural Route Number,
bepital or Attending Physician: The law requivours after death.  Journal Director: After this certificate has been by filled in by the funeral director, page 2 should be considered to be completed.	redical certification: 10 be	examiner?  1	28a. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunct	ry y, Year) 28b  28b  28c  28c  28c  28c  28c  28c	p. Time of Injury farm, stre	28c. Injury Work M 1 1 2 et, factory, office occurred at the tire estigation, in my o	en: 4 Nursing Ho	h (Check only one 5 Res 28d. Describe 28f. Location of City or To	Street a cause(, date ar	and Number or Rele) s) and manner and place, and due ate signed (Monta	ural Route Number, s stated. e to the cause(s)
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	To the Hospital or within 24 hours efter To the Funeral Dir	completely filled in	Medical Cert
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		Please Type or Print in Black State of Maryland / D			-	_			
		For State Registrar	Reg. No. 2009 1367						
		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death		
Physicia /Medic		ELLEN S. CIRUL			April :	28, 2009	1:25 PM		
Examin		4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of Deat			
Francis		Genesis Eldercare  5. Social Security Number 6. Sex 7. Age (In yrs. last birth		rna Park	8 Date of Birth	Anne A	thplace (State or Foreign		
Funeral Director		, Du 1875	rs. Months Days	Hours Min.	(Month, Day, 03/08/	Year) Co	arvland		
pu »		Usual Residence of Decedent	or Location				10d. Inside City Limits		
laryla i shov	ō			) 1			1 □Yes 2 No		
the Maryland r 28a-f show notified at	rect	MD Anne Arunde1	10f. Zip Code	asadena	10	g. Citizen of What Co	ountry?		
ath with 23a or	Funeral Director	228 Arundel Road	21	122		U.S	.A.		
ems sermi	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
s after	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ⅳ No ————————————————————————————————————	1 □Yes 2 No		,	Specific			
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	edb	15. Decedent's Education 16a. I	Decedent's Usual Occu		1	6b. Kind of Business/	hite Industry		
hin 72 e. an "ne	plet	(Specify only highest grade completed) (	Give kind of work done life. DO NOT use retire	during most of working ed)	ng				
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be fill ntai H ed ott	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		,			
should and Mer marke umatic	ဥ	P Edgar W. Coghill Fannie E. Kraft  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zi,							
and 2 s ealth au n 27 is ner trau			3 12th St						
as 1 a of Hei			Disposition (Name of crematory or other pla			0c. Location - City or			
Pages ment of ant: if it ury or o		1 Buriai 2 Cremation 3 C Removal from State	wn Cemete	ery 05/0	2/09	Baltimor	e, MD		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exonce.		21. Signature of Eureral Service Licensee	22. Name and Addr	ess of Facility G. era Driv		Funeral			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between							
Physician		Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE (ARDIOMWOPATHY VEARS							
/Medical Examiner		Due to (or as a consequence of	):	,					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):						
e executed ian and unal-transit	Examiner	that initiated events C.							
oe exe cian a vurial-t	- 1								
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medica	d							
eath certifi attending p for use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	livery		
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res th signed	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause gi	iven in Part I.		acco use contribute to	robably 4 Unknown		
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he law e has ige 2 s	gmc				24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of		
sician: The lacetificate ha	Be Co	25. Was case referred to medical		26. Place of Death	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2 No		
Physici this cer al direc		examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Out	patient 3 DOA Ot	har		nce 6 Other (Spe	cify)		
Attending Physician: r death. ector: After this certificaby the funeral director, p.	ü	TENAMIA SETERIARY	ury Wo	ork?	28d. Describe how	v injury occurred			
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of or A	Certification: To	4 Homicide determined building, etc. (Specify)	, on ook idetory, on oo		City or Town,		star ricoto ivenibol,		
Hosp 14 hou Funer tely fil	Medical C	29a. Certifier  1 Certifying Physician: To the best of my knowledge, (Check only one)  1 Medical Exeminer: On the basis of examination and and manner stated.	death occurred at the /or investigation, in my	time, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)		
To the within 2 To the comple	Me	29b. Signature and title of certifier		se number	29	d. Date signed (Mont	h, Day, Year)		
		Im (" will an w)	D	31136	A	PRIL 28	2009		
[. V		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	1	01		2009 MD 21736		
رو ۷ Sta	.0	BRIAN C-WALLACE, Wi), 900 31. Date filed (Month, Day, Year) 32. Register's Signature	DS KILBR	11)E KD	DALT	more,	MD 21736		
Registra									
HMH 17 Rev 1/20	01	APR 2 9 2009 Lenna B.	park						
			ORIGINAL						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month **Physician** Elizabeth Roseanna Cignatta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Franklin Square 5. Social Security Number 6. Roseda Baltimore Hospital enter Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. 1 □ M 2 🛛 F Months Davs 1/24/1918 Maine 219-20-5014 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, its Medical Examiner must be neditived at 1 ☐ Yes 2 No Director Maryland Baltimore Essex Cignatta, Elizabeth Baltimore, Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? 10e Street end Number U. S. A. 21221 by Funeral 8 Branch Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐XNo if Yes, Give Year or Dates: Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 1 and 2 should be filed withit Health and Mental Hygiene. Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Gormley ဂ္ Albert Oualey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Essex, Maryland 21221 8 Branch Street James Michael Cignatta (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition /28 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Baltimore City, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Richard 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. C. 20 50 Approximate Interval Between Onset and Death Immediate Cause (Final Se. Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sinus Syndrome 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Hypertensian 25. case referred to medical examiner? 1 TYes 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural after death. 1 Director: After to in by the funeral (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00065094 NGUYEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Ballimore, MD 21237

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day, Year)

APR 2 9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15AM **Physician** berta 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore uturecare If Under 1 Year | II Under 24 Hrs. 7. Age (In yrs. last birthday) 95 Yrs. 8. Date of Birth (Month, Day, Aug. 14 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Mayland 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 3824 Garrisa Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14 Bace - American Indian 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Baltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Bottle Maker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Continental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: If Item 27 Ie marked other tha any Injury or other treumatic event, that ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown enrietta Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/229 19a. Informant's Name/Relationship (Type, Print) Clar Coichester Sarah 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Dourial 2 Cremation 3 Removal from State Marla 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Salsenno Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq nice of) Examiner sate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed K chest Due to (or as a consequence of) P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Jar 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes 2□ No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Maturat 5 Pending investigation after death.

Director: Aft ·1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cedifies 29c. License number MD D 31464 4/29/69

State Registrar

DHMH 17 Rev 1/2001

APR 2 9 2009

STOALLS A. HOSKIMIMD.

31. Date liled (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Senera S. Jarle

821

ORIGINAL

N. ENTAN ST SHIR IN BALTIMORE MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ARTINE COXTES 46AM DR 2009 /Medical 4c. Coupty of Death Examiner owce cimbia ounter General If Under 24 Hrs. 8. Date of Birth (Month, Day, se (State or Foreign ocial Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Bi **Funeral** Months Days 5 1 🗆 M 💋 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code Completed by Funeral death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examina once. Black, White 1 Never Married 2 Married 21215-0036 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (1-12) College (1-4or 5+) Baltimore, Maryland Feiner's Name (First, Middle, Last Be tarrison ဂ္ဂ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Husband 19a. Informant's Name/Relationship (Type. Print) cater torest Garden Ave GWANN 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Denation 5 ☐ Other (Specify) ignature Funeral Service Licensee 22. Name and 23a. P. J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart ailure. List only one cause on each line. rm diate Cause (Final sase or condition sulting in death) **Physician** Athenoscle /Medical Due to (or as a consequence of) Examiner AEGROUNSCO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 □Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Medical Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □Yes 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 20, 2009 08:41A M Carpenter Josephine Alice Apri1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton . Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2🗓 F 03-18-1924 NC 579-78-9644 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventral per must be notified at annex. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Charles County MD 1X Yes 2 □ No Waldorf Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 5910 Michael Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife/Self Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Bradley John Moody ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type. Print) 2031 Brooks Drive Apt. 817 Forestville, MD Sammuel Carpenter/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/24/2009 Suitland MD 4 □ Donation 5 □ Other (Specify) NE Washington, DC 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Dunn&Sons 5635 Eads St. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** convert /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Vear Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 | No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a cate has been signed by page 2 should be detach certificate filled in by the funeral director, this after death. within 24 hours a

and

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

ures

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🛩 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D46478

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend 28b & 28f, perME 8891 5/8/09 TT

State of Maryland / Department of Health and Mental Hygiene 3682 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 23 4. 0505 ANNELISE 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHOCK TRAYMA CENTRE BALTIMORE - UMMS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 KF Min. 0970271935 Norway 239-58-0386 73 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f shiner roust be motified 1 XYes 2 PNo Funeral Director FT. Volusia Port Orange 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5200 South Nova Road, Lot 257 32127 s 1 and 2 should be filed within 72 hours after death v if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates: Specify. þ Specify: 3 XWidowed 4 ☐ Divorced Completed event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Folf Haslum Ruth Solveig မ Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Zanda, Son 255 Webbs Lane, Apt. F-22, Dover, DE 19904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 04/28/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Trader Funeral Home T.Harman Str 12 Lotus Street, Dover, DE 19901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 RAUMATIC INTURY /Medical Due to (or as a consequence of): Examiner MOTOR VEHICLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1☐Yes 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 11 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After Injury Z 5 Pending 1 Matural MOTOR VEHICLE COLLISION 2 Accident investigation 1 ☐ Yes 2 ☑ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Newburton Kd** determined 4 Homicide ROAD MACHONDY within 24 hours a To the Funeral D Dover, DE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number KESIDENT MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LA ERDENE ST. S. BALTMIKE MD, 21201 SHOCKTRAUMA CENTRE PATEL 31. Date filed (Month, Day, Year) State Down S. park Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4/27/09 1:45 El Dawkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** USA Baltimore -#223 3501 Howard Park Ave Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 248-48-4684 SC 7/23/34 74 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore N/AMD Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21207 3501 Howard Park Ave #223 Funeral 14. Race - American Indian, Black White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ^{Specify}American 1 ☐ Yes 2 🗙 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Finisher 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Barnes El Dawkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Howard Park Ave #223, Balt., MD 21207 19a. Informant's Name/Relationship (Type. Print) Shirley Dawkins/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem Pk Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/09 Arbutus, MD 22. Name and Address of Facility
Hari P. Clo 21. Signature of Funeral Service Livensee 5126 Belair 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the configuration of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the attending p for use as t yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Satural 5 Pending investigation of Funeral Director: Aft fulled in by the fun filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 -- Ufying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) completely and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number While 39 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Kushstown

25

31 Date filed (Month, Day, Year)

Man Smet

Registrar's Signature

Amend 19b, perFh 8890 4/29/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month GILBERT A. DeWITT, SR. 1:15PM April 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore County 130 ELINOR AVENUE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 🕅 M 2 🗆 F Min 160-18-2893 89 Director 26,1919 Dec. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√XNo Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21236 USA 130 Elinor Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★★★Yes 2 □ No If Yes, Give WW 1. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 □ Yes ŽŽNo White WW 11 Specify þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any Injury or other traumatic event, I'm Jone. Local 16 Iron Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar DeWitt ပ Sophie Miller 19b. Mailing Address (Street and Number or Rural Rowe Number - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gilbert A. DeWitt, Jr. (Son) 1601 Carriage Hill Dr. Westminister, Md. 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State My Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4~30~2009 4 ☐ Donation 5 ☐ Other (Specify) Westminster, Md. ^{22.} Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee E. J. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8 nonm value disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed RO attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown been signed be should be deta Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed s certificate has b irector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? motions 2 | No 1 ☐ Yes director, 25. Was case referred to medic examiner? Be 26. Place of Death (Check only ope) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this eral 28a. Date of Injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 atural 2 Accident 1 ☐ Yes 2 No after death Director: 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifie 29d. Date signéd (Month, Day, Year) 70027693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6530 Wolthen Ave Bol 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:48 P 2009 April Tanva Ann Deshields /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Hospice Timonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 F Months Days 50 Director 202-48-2938 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hocial Exercises must be notified at 1 ☐ Yes 2X No Baltimore MD Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 1602 Riverwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 □Yes 2X No Specify: specify: Africian American Baltimore, Maryland 21215-0036 <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Administration Assistant Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Dickson Rodella Bryant Joseph ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 618 Jessop Place York, PA 17403 Bruce A. Dickson - Brother of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of 1 Important: If it any injury or o 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4-29-09 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9200 Liberty Road Randallstown, MD 22. Name and Address of Facility of Funeral Service Licensee Whie Funeral Home PA of Baltimore, County 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 3 Ectopic pregnancy Month Year Day 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 2 🗆 No 1 ☐ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitioner estated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

JACKIE JONES,

30. Name ang add

the

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2009

TANYANN DESHIELDS

2300 DULANEY VALLEY RD. CRNP 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 29 2009

ress of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Ciale of Ma	•	ertificate of L		Reg. I	2009	13686
	Physicia		1. Decedent's Name (First, Middle,	Last)	-			Date of Death     Month     I	Day Year	3. Time of Death
	Physicia /Medic	al		nhardt Dol	1	# 0" T	- I	April 23,	2009 4c. County of Deat	5:50 A M
	Examin	er	4a. Facility Name (If not institution,			0dent	Location of Death		Anne Ar	
	Funeral		1883 Bucklina A	6. Sex 7. Age	(In yrs. last birthd	0 00 00 00	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign untry)
	Director		139-24-4507	1 <b>X</b> M 2□ F	79 Yrs	s. Wonth's Days	Hours Will.	June 13,	1929 Ne	w York
	ww		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	r Location				10d. Inside City Limits
	Maryk -f sho	tor		Arundel	0der	nton				1 □Yes 2X No
	h the	Directo	10e. Street and Number	Tunder	Odel	10f. Zip Code		10g.	Citizen of What Co	untry?
	or death with the Marylan Items 23a or 28a-f show		1883 Bucklina A			2111			Inited St	
	er dez Items	Funeral	11. Marital Status	12. Was Decedent Ender Armed Forces?	ver in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
336	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the McGeol Evin far roust by Indiffice a	Ď	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1X Yes 2 No If Yes, Give Year or Dates:	951-78	1 □ Yes 2 □XNo	Specify:		Specify:	hite
2-0	72 hou	eted	15. Decedent's (Specify only highest	s Education	1 (6	ecedent's Usual Occup	durina most of work		. Kind of Business/	Industry
21215-0036	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		fe. DO NOT use retired	d) -		TIC Assemble	
2	filed w Hygie ther t		12 17. Father's Name (First, Middle, L	.ast)		Postmaster		e (First, Middle, Maid	US Army den Surname)	
au	d d d	To Be	Franz Do				Ros	a Fische	er	
Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. is marked other than "natural", or items raumatic event, in "Nacion Expression".	-	19a. Informant's Name/Relationsh	ip (Type. Print)	19b. M	lailing Address (Street	and Number or Ru	ral Route Number, Ci	ty or Town, State, 2	Zip Code)
χ́ Σ	1 and 2 Health em 27 i		Marilynn Lois Do	oll/wife	188	B3 Bucklina	a Avenue		Maryland Location - City or	
altimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once</u> .	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State		isposition (Name of crematory or other place			denton,	
<u>=</u>	permit. Pages Department of Important: If it any injury or c		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		west Art	undel Crema 22. Name and Addre Donaldson				
Ba	permit. Departr Importa any inji	12	Vunita R	Thomas	М00957	1411 Annar				
			23a. Party. Enter the disease, or shock, or heart failure. List of	complications that caused only one caused in	the death. Do not	enter the mode of dying	ng, such as cardiac		400	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	-a. Arte	riose	berotic	HEAR	+ /15	CAS-R	Office and Double
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)	12 1 10				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (v) as a	consequence of)	15/10 10				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	a. DIA	bete	9				U.
90,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of)	:				
68760,	rificate be executed og physician and as the burial-transit	Medical		d						
		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 Ectopic pregnance	214		23d. Date of de	
<u>.</u>	Physician: The law requires that the death ce this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify)			Month	Day Year
P.O.	ires that the de signed by the a 1 be detached f	Phy	9 ☐ Unknown  Part II. Other significant condition		t not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
ds,	lires the signed dipe of	d by	Tarrii. Other significant contains	3 33.11.124.11.19 10 2021.1				1 ☐ Yes	2 □ No 3 □ P	robably 4 Di Unknown
cor	w require s been si should b	Completed						24a. Was an	24b. Were a	utopsy findings available
æ	The law te has age 2 s	ошо						autopsy performer 1 □ Yes 2	d2   death?	completion of cause of s 2 □ No
ital	slan: ertifice ctor, p	BeC	25. Was case referred to medical examiner?					ath (Check only one)		
of <	Physle this o	0	1X1Yes 2□No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	attent 3 DOA		lome 5 Residenc		ecify)
ono	ding h. After funer	tion	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investig	g (Month, Day	(Year)	ury Wo	rk? ]Yes 2□No	Esa. Deconice now	mjery ocouniou	
Division of Vital Records,	Attending r death. ector: Afte by the fune	ifica	3 Suicide 6 Could r	not be 280 Place of Inju	ry - At home, farm	n, street, factory, office	-	28f. Location (Stree City or Town, S	et and Number or Fi	Pural Route Number,
Ö	tal or rs afte al Dir	Certification: T								
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of Examiner: On the basis of						
	o the	Med	29b. Signature and title of certifier	and mariner sta	Depu	44 29c. Licen	se number	29d	. Date signed (Mon	th, Day, Year)
	->-0		Mallin	Halos	mo	D	0605	4	4/23	17
1			30. Name and address of person	who completed cause of de	eath (Item 23a) (T	ype, Print)			, 1	1033
			31. Date filed (Month, Day, Year)	3. Registra	ar's Signature	0 69	15 1	meric	A d	1000
	Sta Regist		APR 29	2009 Destus	1. 14	for investigation, in my  29c. Licen  D  ype, Print)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 22, Robert Franklin DeMilt, Sr. April 2009 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Brighton Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F 070 - 18 - 4374April 10, 1924 Director 85 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Mental Expension once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8227 Tuckerman Lane 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔯 No Specify. þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Benjamin DeMilt မှ Marie Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 420 Fairlea Drive, Edgewater, Maryland 21037 Gloria J. Shannon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 4, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specify) Entombment Gate Of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service License M01548 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** <u> Aortic Stenosis</u> Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∏Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 █️Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 29c. License number

V

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Jan (Bachowski 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person

32. Registrar's Signature 3. park

no completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

**ORIGINAL** 

D35370

1 N 25 Rockville Pike, #104, Rockville, Maryland 20852

April 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 8:15 PM April 27. 2009 Darling Elbourn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Nursing Center Timonium Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number **Funeral** Sex 1 M 2 □ F Months Days Hours Indiana 10/5/1919 89 Director 315-05-4836 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10a. State s 23a or 28a-f show wat be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 S. 3200 Everlasting Lane U. Α Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. Completed by 3 XWidowed 4 □ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrical Engineer item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Lois Darling P Howard Elbourn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1704 Old Eastern Avenue Essex, Maryland 21221 Robert Hartnett (Step Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State <del>2</del>688 Baltimore City, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any it Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Fssex, Maryland 21221 50 Lichard C. 20 plia 23a. Part 1. Enter the disease, or constraint ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nei the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 5 Other (specify) ☐Yes 2☐No o 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an ELBOURN autopsy 2 No 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospital or Attending Phys 24 hours after death. Funeral Director: After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

NURSE PRACTITIZEGNER Medical within 2. X 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature and

APRIL

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year) State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

21093

TIMONIUM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 2 Õ 2009 10:00PM Jessie L. Foxx /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1606 Lemmon St. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 3 / 1 2 / 1 9 3 6 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F 73 Director 237-54-7642 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Evaminar must be notified at X□Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 21223 Funeral 1606 Lemmon St 12. Was Decedent Ever in U.S. Armed Forces? 1≿[Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2XNo ģ Specify: Black 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Petroleum Service permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the arry injury or other traumatic event, Its and eary injury or other traumatic event, Its and eary Laborer 12th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Palmer Hubert T. Foxx ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Lemmon St. Balto., MD, 21217 Joel Waddell/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/09 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor St. Balto., MD, 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastat /Medical Due to (or as a consequence of): Examiner uno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Micotine physician and s the burial-trans Due to (or as a consequence of): by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f I □Yes 2 □No 9 Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Mayes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 275 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after death.

I Director: A

id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed P.O. Box 68760 f  $\mathcal{A}$   $\mathcal{L}$   $\mathcal{A}$   $\mathcal{L}$  Division of Vital Records, or Attending Physician: within 24 hou To the Fune completely fi

with the Maryland

death v

filed within 72 hours after

Maryland 21215-0036

Baltimore,

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day. Year)

39. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Re

13690

		•	1 - State Registrar	Otate of Wie	Ce	ertificate of			Reg. No.	.000	, 00	
٤,	Physici	an	1. Decedent's Name (First, Middle,					2. Date of De Month	Day		3. Time o	
	/Medic		Dorothy L.	Fearson				April		2009	6:35	РМ
1	Examir	er	4a. Facility Name (If not institution,				or Location of Death					
		.# _{0,7} 8	15827 Easthaven 5. Social Security Number		e (In yrs. last birthda)		SOWIE r   If Under 24 Hrs.	8. Date of Bir	<u>   P</u> 1	rince Ge	-lane /Ctate	on Comina
	Funeral Director	1	579–05–4046 Usual Residence of Decedent	1 ☐ M 2 🔀 F	91 Yrs.	Months Days		8. Date of Bir (Month, Da 9/18/	1917	Wash	ingtor	ı,D.C.
	the Maryland 28a-f ehow notified at	٦٢	10a. State 10b. County 10c. City, Town or Location								10d. Inside C	ity Limits
	28a-f	ect	MD Prince	e George s		10f. Zip Code	<u> </u>		10g Citi:	zen of What Cou	intry?	-
	23a or	흡	15827 Easthaven	Court		20716	5			USA	,,,	
	me 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	)*·	14. Race - Amer		
21215-0036	72 hours after death with the Maryland *naturel; or iteme 23a or 28a-f ehow calcal Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 1  If Yes, Give Year or Dates:		1 Yes 2 No		o rican, etc.)	-	Black, White Specify: Wh	ite	
2-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occi	pation e during most of wor	rking	16b. Kir	nd of Business/la	ndustry	
2		Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) /ife.	DO NOT use retir	ed)		Or	vn Home		
	filed withi Hygiene. hther ther	S	12. 17. Father's Name (First, Middle, L	act)	Н	omemaker	18. Mother's Nar	ne (First Middle	1			
and	ntal h	Be c	Raymond Reed	,			Marie	McDerm		our amo,		
Maryland	2 should be filed withir and Mental Hygiene. ie marked other then aumatic event, IDEM	၉	19a. Informant's Name/Relationsh	o (Type, Print)	19b. Ma	ling Address (Stree	at and Number or Ru			r Town, State, Zi	ip Code)	
Z	s 1 and 2 should be filled within f Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the M.		Margaret A. Jos			7 Forest		wie, MD				
ē,	s 1 and 3 Health Item 27 other tr		20a. Method of Disposition			position (Name of ematory or other p		Date		cation - City or T	own, State	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		1 ☐ Burial 2 <b>XX</b> cremation 4 ☐ Donation 5 ☐ Other (Sp			Cremator		2009	Balt	cimore,	MD	
alti	mit. I partm ports. / inju		21. Signatu e of Funeral Service L			22. Name and Add				eral Home		
Ö	99 5 8 9		6512 NW Crain Hwy. Bowie, MD 20715									
	Physician /Medical Examiner	-0	23a. Part 1. Enter the disease, or populications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List dry one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to ammediate cause. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									ite itween Death
68760,	rificate be executed ng physicien and as the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
Box .	that the death certifed by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 1 No 1 Yes, Outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)						23d. Date of delivery Month Da		
ds, P.O.	es peq	þ	Part II. Other significant condition	1 0	ut not resulting in the	underlying cause (	given in Part I.		id tobacco use contribute to the cause of death?			1
202	> 0 5	Completed		11/1	-			24a. Was	an	24b. Were aut	opsy findings	available
Re	has has	Ę.						auto perfe	psy ormed?	prior to c death?	ompletion of	cause of
a	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath Check only	_	1 Ll Yes	2 🗆 No	
>	Physician: this certific al director,	0 0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpati	ent 3 DOA	Other: 4 Nursing H		-	6 ☐Other (Spec	ufv)	
0		H	27. Manner of Death	28a. Date of Inju		of 28c. In		28d. Describe				
Ö	ath. r: After	atio	Natural 5 Pending 2 Accident investig	ation	y rear) Injury		☐Yes 2☐No					
Division of Vital Records,	al or Atte s after de- il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	286. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, offic				d Number or Ru.	ral Route Nur	mber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (		Physician: To the best xaminer: On the basis o and manner st	f examination and/or							s)
	To the within To the comp	W	29b. Signature and title of certifier	\ lu	nn 1		nse number			te signed (Month		
1	V	1	30. Name and address of person v	V	leath (Item 23a) (Typ	e, Print)						-
Ψ	200		Richard J. Feld		9500 Annar	polis Rd.	Ste. A-4	Lanhan	n, MD	20706		
-	St Regist		31. Date filed (Month, Day, Year)  APR 2 9 2009		ar's Signature	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year tarmer 235 P M **Physician** April 2009 rancesta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) . Dale of Birth (Month, Day, Year) 10-28-1949 **Funeral** Days 1 DM 2 😿 F 032-42-2963 59 N.C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Baltimore [10f. Zip-Code MD 10g. Citizen of What Country? 10e. Street and Number 21218 2514 N. S Calvert Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed 12th Grade vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred E. Farmer, Hilda Harrell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19701 Bear Niambi Love - DAUGHTER Paxton Lane 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H important: If ite any injury or ot once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-29-2009|Baltimore, MD Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonar ertensic **Physician** Hy Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, south is triminal cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a conse uence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 - Fetal death Live birth 3 🗌 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 I Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1Xinpatient 1 ☐ Yes 2 No ၉ After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h. Time of 28c. Injury at Work? Certification: Injury 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No М death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be determined à 4 \ Homicide 6 filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES - 000

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

31. Date filed (Month, Day, Year)

			State Registrar	Ce	ertificate of Death	Reg. N	lo.
	Physici: /Medic		1. Decedent's Name (First, Middle, Last) Ve(non Fav	iklin		4 1	year 3. Time of Death 6:10 PM
1	Examin		4a. Facility Name (If not institution, give st	al	4b. City, Town, or Location of Death Baltimere		c. County of Death
	Funeral Director		5. Social Security Number  214-40-0507  Usual Residence of Decedent	7. Age (In yrs. last birthday Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Maryland a-f show	tor	10a. State 10b. County	10c. City, Town or L Balti M			10d. Inside City Limits 1 X Yes 2 ☐ No
	th with the 23a or 28 Ist by not	Funeral Director	10e. Street and Number 1686 Poles Road	1	10f. Zip Code 2/22/	10g. C	Citizen of What Country?
9800	be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the "Actical Frem her must be neithful at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F  1 □ Yes 2 No Specify:  edent's Usual Occupation	lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry
21215-0036	filed within 72 Hygiene. yther than "nal snt, ne wede	Completed by	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed)   (Give	e kind of work done during most of working DO NOT use retired)	9	sawyer Man
Maryland	should be filed vand Mental Hygis s marked other umatic event, tr	To Be C	17, Father's Name (First, Middle, Last) LIUSO LIONE!	Franklin	Matilde	(First, Middle, Maide Q Eliza	beth Hill
, Mar	ss 1 and 2 should of Health and Mer fitem 27 Is marke r other traumatic		19a. Informant's Name/Relationship (Typ	168	ling Address (Street and Number or Rural	Balto, 1	ld. 21221
Baltimore,	permit. Pages 1 Department of H Important: If itel any injury or otl once.		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Ludar Ludar	position (Name of ematory of other place)  22. Name and Address of Facility	1/09 OK	Florence Funeval Serv.
		S 17	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final	e cause on each line.	nter the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	ilute	ungs	I week
68760,	be executed siclan and burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B ☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that in signed build be deta	þ	Part II. Other significant conditions con	ributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	sician: The law requir s certificate has been s lirector, page 2 should	Completed				24a. Was an autopsy performed 1 □ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
/ita	cian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of Death		· · · · · · · · · · · · · · · · · · ·
<u></u>	Physion this cal dire	မ	1 ☐ Yes 2 DHNo	ospital: 1 Inpatient 2 ER/Outpati			6 Other (Specify)
uc	ding F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury		28d. Describe how in	ijury occurred
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	he Hospit in 24 hour he Funera pletely fille	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	Ician: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To the vithing to the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the	×	29b. Signature and title of certifier	ll	29c. License number  RES-001	29d.	Date signed (Month, Day, Year)
			30. Name and address of person who co			nde, M	aryland 21225
	Sta Regist		APR 2 9 2009	Sener S. Jan	Kel	*	

Physician/Medical Examiner

spital or Attending Physician: The law requires that the death certificate be executed outs after death.

Leral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burta-transit To the Hospital o within 24 hours aff To the Funeral Di

Completed by

Be

2 X Accident

3 ☐ Suicide

4 Homicide

(Check only one)

P.O. Box 68760.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d	42809
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
	-, A-5, b, m,	Did tobacco use contribute to the cause of death?  1 □ Yes 2 ₺ No 3 □ Probably 4 □ Unknown
		Was an autopsy findings available prior to completion of cause of death?  √es 2 No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check of	only one)
examiner? 1∭Yes 2□No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5	Residence 6X Other (Specify) Hospice
27. Manner of Death  1 □ Natural 5 □ Pending		ribe how injury occurred

8:00 P

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Certification: To 29b. Signature and title of certifier Jocetyne 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Kouel	chou,	mD	
	f 1 - 1 - 1 - 00		

4/10/09

Home

29c. License number

1 Tyes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

15401 Bassett Lane #2E Silver Spring,MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Trip and fall

3. Time of Death

6:18 P

10d. Inside City Limits

White

1 □Yes 2 N No

200 63 748

2X No

April 28, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

determined

6 ☐ Could not be

6001 Muncaster Mill Rd., Rockville, Maryland 20855 Jocelyne Toukep Kouatchou, M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 8:50 am Tras nry 2009 irginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frankford Nursing Repobilitation Center 8. Date of Birth (Month, Day, Year) Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 M 2 TF 90 Director 218-18-9267 19 Usual Residence of Decede permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No **Funeral Director** MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U • S • A •

Race - American Indian,
Black, White, etc. 4935 Aberdeen 21206 Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Clerk Social Security Adm. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Hezekiah Gross Ann M. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Woods-Sister 4935 Aberdeen Ave, Baltimore, Md 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 Removal from State Memorial Park 4/29/09 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 23a. Dan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) emer 19 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Let ur Jerry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760; physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably + Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Harsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

PR 2 9 2009 Sertina B. Sparke

Thom Woods load. MD 21234

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) N99 awrence 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) 5. Social Security Number 03-19-1946 Months Days Hours 1**X** M 2 □ F MD 212-44-8542 63 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X Yes 2 □ No MD N/A Baltimore 10g, Citizen of What Country? 10f. Zip-Code 10e. Street and Number 1225 Beaumont Avenue 21239 SA TT 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married Married X Yes Yes, Give 1 ☐ Yes 2 💢 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done d life. DO NOT use retired) during most of working (Specify only highest grade completed) Social Security College (1-4 or 5+) Elementary/Secondary (0-12) Administration N/A File Clerk 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Green Edna Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Name/Relationship (Type. Print) Lelitia Royal-Daughter 1565 E. Northern Parkway Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 5-5-2009 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la Balto, MD 21202 1101 E. North Avenue w a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OX disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions f any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last Due to (or as a consequence of) FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day in the past 12 months?

**Physician** /Medical **Examiner** 

Department of Healt Important: If item 2 any injury or other once.

burial-tran

within 24 hours aft

To the Funeral DII

completely filled in

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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Me

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

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"natural",

Director

Funeral

2

Completed

Be ပ္

injury or other traumatic event, the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than

Maryland 21215-0036

Baltimore,

permit.

Examiner	Sit coot
Certification: To Be Completed by Physician/Medical Examiner	1 2
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1   Yes 2   No 9   Unknown		Unknown		unei (	specify)			
Part II. Other significant of	conditions contributin	g to death but not re	sulting in the unc	lerlyin	ng cause given i	n Part I.		use contribute to the cause of death?
ompleted							24a. Was an autopsy performed? 1 Yes 2 M No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
25. Was case referred to rexaminer?	nedical Hospita	5			Othor		ath (Check onl one	
o 1 🗆 Yes 2 🗖 No	поѕріта	1 Inpatient 2	ER/Outpatient	3 🗆 1	me 5 Residence 6 Other (Specify)			
<ul> <li>27. Manner of Death</li> </ul>	Pending investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗌 No	28d. Describe how injur	ry occurred
1 Natural 5   2 Accident 3   Suicide 6   4 Homicide	Could not be determined 28e	Place of injury - At h building, etc. (Speci		, facto	ory, office		28f. Location (Street ar City or Town, State,	nd Number or Rural Route Number, )
29a. Certifier 1 X C	ledical Examiner: Or	To the best of my known the basis of examination	owledge, death o ation and/or inves	ccurre	ed at the time, dion, in my opinion	late and place on, death occ	e, and due to the cause(s curred at the time, date an	and manner as stated. d place, and due to the cause(s)

29c. License number

0

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

Debrai

29b. Signature and title of certifie

30. Name and address of person v

Mukheyee

completed cause of death (Item 23a) (Type, Print)

		State of Maryland / Department of h			ene g. No. 2009	9 13696
Physici		1. Decedent's Name (First, Middle, Last)  Shirley Greenawalt		2. Date of Death Month		3. Time of Death 5:45 A. M
/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, c	or Location of Death	APITI	4c. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 217 56 9175 1 M 2 X F 60 Yrs. Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 02/28/1	Year) 9. Bir	thplace (State or Foreign ountry)
ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Arundel  Baltimore				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the 3a or 28a	Il Director		1225	10	og. Citizen of What Co	ountry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event has a bondified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036 d within 72 hours aft gliene. er than "natural", or er than "natural", or the Wedforl Event.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 10th  16a. Decedent's Usual Occul (Give kind of work done life. DO NOT use retire Clerk	during most of work	ing	6b. Kind of Business	
Maryland 2 nd 2 should be filed atth and Mental Hygi 27 is marked other r traumatic event,	To Be Co	o 17. Father's Name (First, Middle, Last)  Alston Edward Dugger Sr	18. Mother's Name	e (First, Middle, M 1 Marie I	laiden Surname)	
Maryla nd 2 should I atth and Men 27 is marke		19a. Informant's Name/Relationship (Type. Print)  Thomas Greenawalt / Son  19b. Mailing Address (Street 4402 Belle Gr				Zip Code) land 21225
altimore, Marmir. Pages 1 and 2 partment of Health a portant: If item 27 is y injury or other trains.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other pla			Oc. Location - City or	Town, State
Balti permit. Departm Importa any inju		21. Signal of Fineral Service Licensee 22. Name and Address	ess of Facility Go:	nce Fune	ral Servic	
Physician /Medical Examiner  Physician and Ithe prival-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Securities is condition at a.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death South
	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	су		23d. Date of de Month	olivery Day Year
rds, P. quires that the signed by und be detact	ed by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives	ven in Part I.	23e. Did tob		o the cause of death?
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be c	Complete			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
In Of ing Phys After this	Certification: To Be	25. Was case referred to medical examiner?	her: 4 \(\text{ Nursing Ho}\) iry at rk?  Yes 2 \(\text{ No}\)	28d. Describe how 28f. Location (Str.	nce 6 Other (Spe w injury occurred eet and Number or R	
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: 4 completely filled in by the fi	al Cert	4 Homicide building, etc. (Specify)  29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the t	time, date and place,	City or Town,	use(s) and manner a	is stated.
<b>To the Hc</b> Mithin 24 <b>To the Fu</b> completel	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.  29b. Signature and title of certifier  29c. Licenses			te and place, and due  d. Date signed (Moni	
		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	31551		April 20	P,2009
Sta Registr		31. Date filed (Month, Day, Year)  32. Rigistrar's Signature	of A.VR	6 /en B	surviylel	40%

Lillie C	atewood		1- For State	ate of Maryland /		rtment of tificate of		d Menta		Reg. No.	200	9 1369
	Physici	an/	Registrar  1. Decedent's Name (First, Middle	e,Last)					2. Date of De	ath	Year	3. Time of Death
Medic ,	al Exami	ner	Lillie R. Ga 4a. Facility Name (if not institution				b. City, Town, or	Location of	Month April 22,		County of Death	1217 hrs
			5605 Dowgate Court #	•			Rockville	20001101101		1	ontgomery	
	Funeral Director		5. Social Security Number 526–17–0074	6. Sex 7. Age	(In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Day			irth(MM/DI 7/196	Foreig	rthplace (State or gn puntry) AZ
	ý		Usual Residence of Decedent		10a City	Town or Location						10d. Inside City Limits
	d tow any e.		10a. State 10b. County AZ A	pache	Tuc. City,	Tsail						1 Yes 2 No
	Aaryland 28a-f show 1 at once	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	intry?
	the M 3a or 2 stiffed		1/4 Mile Sout	h Tsaile Cre	ek Bı	ridge	8655	56		United States		
	r death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status  1 X Never Married 2 Ma	12. Was Decedent Armed Forces?					n? (Specify Yes or N Puerto Rican, etc.)	lo- 1	<ol> <li>Race - Amer White, etc.</li> </ol>	ican Indian, Black,
	her des			1 Yes 2 orced If Yes, Give Year	X No	1	Yes 2 X No	specify:		s	ipecify: <b>Am</b> ∈	erican Indian
	nours a	ed by	15. Decedent's Education (Spec				's Usual Occupa		nd of work done 16b. Kind of Busine se retired)			findustry
35	in 72 h	plet	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		ountant		,		I	Accounting
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2424	d be fillental Flarked	o Be	Woodrow Gates  19a. Informant's Name/Relationsh			40h Mailine	Address (Our		ine Brown per or Rural Route No	b.a.a Cit.	. as Taura Chat	a Zin Cada)
MD	2 shoul h and N 27 is n	ř	Magline Brown	, , , , ,					ile, AZ 8		or rown, State	e, Zip Gode)
9	i I and FHealtl Fitem		20a. Method of Disposition  1 X Burial 2 Cremation	2 Romoval from Str		Place of Disposi crematory or oth	ition (Name of ce	emetery,	Date	20c. Lo	ocation - City or	r Town, State
Baltimore	Pages ment of tant: 1		4 Donation 5 Other Sp	ecify:	Cor	munity	Cemeter	-	04/30/200			· .
4	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I gold to effled within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Furteral Service	Licensee T.H	armaı		ame and Addres		Silver ( Tse Bonit			
	hysician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		the death.	. Do not enter th	ne mode of dying	, such as ca	rdiac or respiratory a	rrest, shoc	k, or heart	Approximate Interval Between Onset and
	xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestinal  Due to (or as a conse								Death
			Sequentially list conditions,	b Chronic Alcohol	ism							
		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of	f):						
V	cuted nd transit	Physician/Medical Examiner	events resulting in death) Last	Due to (or as a conse	equence of	f):						
4	be exe sician a	edica	UNPENDED	AMENDED								
976	leath certificate be executed eattending physician and for use as the burial - transit	m/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 23c. If yes, outcome	ne of preg		tal death 3	Ectopic	pregnancy	l l	. Date of deliver Month	ry Day Year
2	attendi	sicia	1 Yes 2 No 9 V Unk	4 Pregnant at time of death 5 Other (Specify)								
a C	that the de ned by the detached i		Part II. Other significant conditi	The second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a section section in the second section in the section is a section section in the section section in the section section is a section section section in the section section section is a section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section section secti	but not re	esulting in the u	inderlying cause	given in Par	t I. 23e. Did	23e. Did tobacco use contribute to the cause of death?		
٥	ires that signed I	d by									No 3 Pro	bably 4 Unknown
, de	ysician: The law requir his certificate has been a director, page 2 should	Completed								opsy	prior to	utopsy findings available completion of cause of
0	The la ficate h page 2	Com							1 ✔ Yes	formed? 2 No	death?	es 2 No
<u> </u>	sician: is certif irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	int 2	ER/Outpatient		e of Death (	Check only one)  Nursing Home 5	Residen	nce 6 🗸 Othe	er: Scene
7	ing Physic After this uneral dir	⊢	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y		28b. Time of I		ury at Work?				
2	ttendir leath. tor: A	atio	1 V Natural 5 Pend 2 Accident Inves		oui,		1	Yes 2	No			
į	Hospital or Attending Ph 24 hours after death. Funeral Director: After tely filled in by the funeral	Certification:	3 Suicide 6 Could	28e. Place of the mined (Specify)	jury - At h	ome, farm, stree	et, factory, office	building, etc	28f. Location or Town		d Number or R	tural Route Number, City
_	Hos 24 h Fun		29a. Certifier (Check only 1 Certifying Ph	nysician: To the best of m								
17	To the within 2 To the complet	Medical	290 Signature and title of certifie	and manner stated.			29c. Licen	se number		29d. D	ate signed (M	onth, Day, Year)
			( alpha	1180			0.0	.M.E.		April	23, 2009	
	7		30. Name and address of person Laron Locke MD. A	who completed cause of c ssistant Medical Exa			Street, Balt	more, MI	D 21201			
		tate	31. Date filed (Month, Day, Year)	32. Fegistra	r's Signati	Ire An	Med					
	Regis	ueli	AFRES	LUUJ LUUN	~	1						

			State of Maryla	and / Dep	artment of H	lealth and	Mental Hy	giene	0000	10000
		'	1 _ State Registrar	Ce	rtificate of L	Death		Reg. No(	2009	13698
Р	hysici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Frederick Allen Hughes		1		April	25	2009	8:30 A M
, E	Examin	ier	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	n		County of Death	raola
F	ıneral	_	6802 Niles Drive 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday,	Laurel If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th Year	ince Geo	lace (State or Foreign
	rector		097-30-3050   ¹⊠м 2□F   73	Yrs.	Months Days	Hours Min.	3/19/1	936	Cour Nev	y York
pu	<b>2</b> -190		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Le	ocation				1	0d. Inside City Limits
Aaryla	fshor	ō		aurel	0000011					1 <b>∑</b> Yes 2□No
the A	28a-	Director	10e. Street and Number	30101	10f. Zip Code			10g. Citi	zen of What Cour	ntry?
h with	23a or	a Di	6802 Niles Drive		20707			U.	S.A.	
deat	ems (	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In. Mexican, Puer	pecify Yes or No	,-	14. Race - Americ Black, White,	
s after	or it	by F.	1 ☐ Never Married 2 【X Married 1 【XYes 2 ☐ No If Yes, Give		1 □Yes 2 No	Specify:			Specify: Bla	
U Z I Z I 3-UU30 filed within 72 hours after death with the Maryland Hygiene.	tural'	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Dec	edent's Usual Occup	ation		16b. Ki	nd of Business/Inc	dustry
<b>6</b> . Bin 72	n "na Assis	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	i (Give	e kind of work done of DO NOT use retired	during most of wor	rking			,
d with giene	ar tha	Completed	12 5+	Prof	essor			Edυ	cation	
al Hy	d other	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nar	,		•	
y a	arke	မ	George Estes Hughes			Martha	Stelama		<del></del>	
VICI 12sh thanc	7 is n traun		19a. Informant's Name/Relationship (Type. Print) Elizabeth Hughes/ Wife		Niles Dr					Code)
t and Heall	tem 2	1 8			osition (Name of ematory or other place		Date		cation - City or To	wn, State
Dartinor Department of	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Madical Evandment is used by natified at <u>once.</u>		1 Burial 2 Cremation 3 Hemoval from State		ematory or other plac ifts Registr	;	8/2009	Hanc	ver, Mar	ryland
mit. F	injur Se		21. Signature of Funeral Service Leansee		22. Name and Addres					
Det D	any ir	6 6	1 505		7522 Conne	elley Dr	.,Ste.P,	Han	over, MI	21076
			23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not er	nter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
Phys	sician	8 4	Immediate Cause (Final disease or condition Lun Cai	ncer						Onset and Death
	edical miner		resulting in death)  Due to (or as a cons	equence of):						
LXU		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	sequence of):						
uted	ınsit	min	cause. Enter Underlying	equotion oi).					4	
exect	ial-tra	Examiner	that initiated events resulting in death) Last c	sequence of):						
VISION OF VITAL MECOTOS, F.O. BOX 00/00, Attending Physician: The law requires that the death certificate be executed in death.	physician and the burial-transit	dical	d							
artifica	ing pt as th	Med	IF FEMALE:							
ath cer	or use	hysician/Me	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregnanc	у		1	23d. Date of delive Month	ery Day Year
e de	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)					,
that t	ed by detac	Δ.	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco L	se contribute to the	ne cause of death?
COLOS v requires	n sigr Ild be	d by					1 🗆	Yes 2[	□ No 3 □ Prot	oably 4 🔀 Unknown
	s bee	olete					24a. Was		24b. Were auto	psy findings available
The E	ate ha	Completed				<del></del>	auto perfo 1 ☐ Yes	psy ormed? 2 <b>X</b> No	prior to co death? 1 ☐ Yes	mpletion of cause of 2□No
lan:	ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only			
Physic V	this co		1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2			4 🗀 Nursing r			6 ☐ Other (Specia	(y)
ding P	After	ion:	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day, Year	r) 28b. Time (	Worl	yat k? Yes 2 ∐No	28d. Describe	how injur	y occurred	
INISIO I or Attendi after death.	tor:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	t home, farm, s		Tes Z LINO	28f. Location (	Street an	d Number or Rura	al Route Number
after after	d in b	Certification: To	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	ecify)	,,,		City or To	wn, State	)	,
the Hospital or	To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	1 "	29a. Certifier  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (C							
the H	the Fi	Medical	one) and manner stated.							
P ± ₹	<b>6</b> 0	2	29b. Signature and title of certifier		29c. Licens				te signed (Month,	Day, Year)
,	/		1 Vann Carlo	7	D2374	პ		4/	27/2009	
	V		30. Name and address of person who completed cause of death (			205 0~0	onhol+	MD ^	00770	
è	Sta	ate	Martin Weltz MD. 7525 Greenwar 31. Date filed (Month, Day, Year) 32. Registrar's Si		r Dr.ste.	ZUJ, GLE	EUDETC,	ביוניז ב	.0770	
	Registi		APR 2 9 2009 22	A. 190	When I					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr.,g890_04/29/09dhb
Reg. No.
Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Holland 17:52 Melvin 04 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4b. City, Indiana Amore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Applys Days Hours Min. (Month, Day, Year)

Toly 5) 1931 **Examiner** Good Samaritan Hospital 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 213-28-709 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Evaninest, just be realthed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 □ No Kulpmor Funeral Director 44 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 178 1138 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces?
Hes 2 No Air Force Black, White, etc. Yes 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify. \$ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Air Conditionine 8 Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Eva ၉ Joseph Nlae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place) generated A9 2 17834 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-30-09 5 ☐ Other (Specify) 4 Donation of Funeral Service Lig 21. Signat 1232 Midvalley Dr. JESSUP, PA 18434 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic **Physician** Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physlcian: The law requires that the death certificate be executed COPD exacerbation with Respiratory Failure attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /MD RES000 04/21/09

State Registrar Maheli

31. Date filed (Month, Day, Year)

APR 29 2009

DHMH 17 Rev 1/2001

Holland, Melvin A

Loch Rowen BW., Baltimore, MD, 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yazdany - 5601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25Day 200^y9^{ar} 11:40 pm м Emma

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Physician

/Medica Examine

**Funeral** Director

Division of Vital Records, P.O. Box 68760,

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er	4a. Facility Name (If not institution, g 5168 Perry Road			4b. City, Town, o	Location of Do	eath	4c. Count	y of Death					
		Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 F	Hrs. 8. Date of Bi	8, Yea() 912	9. Birthplac	e (State or Foreign				
	212-30-4679 Usual Residence of Decedent	^{1□ M 2} ∏ F 97	Yrs.	Wioritris Days	Hours	March	8,~1912	Country	MD				
ctor	MD 10b. County Cari	roll 10c. City	, Town or Loc	Mt. a	iry			10d.	Inside City Limits  1 Yes 2 No				
Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of		?				
ral	5168 Perry Road				.771		USA						
nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. Vi	as Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	0- 14. Ra Bla	ce - American ck, White, etc.						
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 1 ☐ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1	□Yes 2 📉 No	Specify:		Speci	^{fy:} Whit	:e				
ete	15. Decedent's l (Specify only highest g	Education grade completed)	(Give k	ent's Usual Occup	during most of	working	16b. Kind of B	susiness/Indus	stry				
omp	Elementary/Secondary (0-12)	College (1-4or 5+)		o not use retired Iomemaker			Dome	estic					
To Be C	17. Father's Name (First, Middle, Last) Raymond Earley  18. Mother's Name (First, Middle, Maiden Surname) Isabel Cook												
	19a. Informant's Name/Relationship	, ,				Rural Route Numi Airy, MD		, State, Zip Co	ode)				
	20a. Method of Disposition	20b. Pl	ace of Dispos	ition (Name of atory or other place	e)	Date	20c. Location	- City or Town	, State				
	1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval nom State		Cemeter		29/09	Balti	nore, M	1D				
	21. Signature of Funeral Service Lice	ensee Hough MO076	4 HA P	AIGHI FUI D Box 195	NERAL HOS	OME & CHA ville, MD	PEL, P., 21784	Α.					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	Immediate Cause (Final disease or condition resulting in death)  a. Dianata High Canada Agents												
	resulting in death)	Due to (or a a consequ	ence of):	11	2	1							
_	Se juentially list conditions.  b. June to far a consequence of the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the first and the firs												
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ğ		d							-				
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy				23d Da						
Physician/Medical Examiner	in the past 12 Months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnand Other (specify)	У			23d. Date of delivery  Month Day Year					
	Part II. Other significant conditions	contributing to death but not resul	Iting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to the	cause of death?				
Be Completed by	<b>3</b>	<b>3</b>		,			Yes 2 No	3 ☐ Probab					
ete							24h	Wara autono	, findings available				
ш						— auto	psy ormed)	prior to comp death?	findings available letion of cause of				
ပို	25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only	2 🗷 No	1□Yes 2l	□No				
Ö	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ B	ER/Outpatient	3 DOA Oth		ng Home 5 ☐ Res		her (Paggifu)					
n: T	27. Manger of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at		how injury occur						
atjo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Year) on	Injury	M 1 🗆	Yes 2 □ No								
tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, stre	et, factory, office		28f. Location	(Street and Num wn, State)	ber or Rural R	oute Number,				
Cer		, , , , , , , , , , , , , , , , , , , ,	,				m, clato,						
Medical Certification: To		Physician: To the best of my know aminer: On the basis of examinat and manner stated.											
Ĭ	29b. Signature and title of certifier	escher =		> 29c. Licens	e number		29d. Date signe	ed (Month, Da	y, Year)				
	Comment !	5		<i>U3</i>	3541		4-	21-0	1				
	30. Name and address of person who	o completed cause of death (Item	23a) (Type, P	Print) Prost	SSWI	7, #114,	Elders	6005 1	nd 21789				
te	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure	0.0		1							
ar	APR 2 9 200	9 Sente S.	gar										

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 26^{Day} 2009^{ear} Ruth I Hotz 2:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Dove House Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 Months | 7ay 940 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) NTT **Funeral** 1 □ M 2 1 F 99 154-22-4245 NJDirector Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, II a I volice Examinating must be nothing at 1 □Yes XX No Director MD Carroll Westminster 10f. Zip Code 21158 10e. Street and Number 10g. Citizen of What Country? 250 St Luke Circles United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married White If Yes, Give Year or Dates 1 ☐ Yes ŽŽNo ð 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It. If "otic once. College (1-4or 5+) Elementary/Secondary (0-12) Grammer School Teacher NJ School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Frederick Elizabeth Walder ပ 19a. Informant's Name/Relationship (Type. Print)
Ruth Ettershank (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Eastman Rd. Randallstown, MD 21133 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Carroll Crematory 4/24/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. 212 W. Old Liberty Rd Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4/23/09-4/28 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine heimer Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Dav Year contribute to the cause of death? Medical Certification: To Be Completed by 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No Other (Specify) ccurred

P.O. Box 68760. Division of Vital Records,

**ro the Hospital or Attending Physician**: The law requires that the death certificate be executed certificate has this After within 24 hours after death.

To the Funeral Director: A

sician and burial-trans attending physician for use as the buria signed by the a d be detached f ficate has been siç r, page 2 should b funeral director, filled in by the

28a-f show

within 72 hours after death with

Baltimore, Maryland 21215-0036

in the past 12 m 1  Yes 2  Unknown	onths?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		c pregnancy (specify)		Month Day Yea
Part II. Other signific	cant conditions	contributing to death but not resi	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of deat
					24a. Was an autopsy performed? 1 □Yes 2 Mo	
25. Was case referre examiner?	d to medical			26. Place of De	eath (Check only one)	
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3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number e)

State Registrar

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 29

30. Name and address of person who completed cause of death (Item

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one)

Be Completed by Funeral Director

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**Physician** 

/Medical

Examiner

Funeral Director

	Please	e Type or F				<b>ink. Ensur</b> of Health a		_	_	ble.	
For State Registrar		Oldic of	war yrari			of Death	110 101		. No. 🥎 🎧	0.0	12701
Decedent's Nam	e (First, Middle, L	.ast)						2. Date of Death	20	UJ	3. Time of Death
Annie			L.		Н	inton		Month 04 2	Day 20	Year	7.15p M
4a. Facility Name (	If not institution, g	ive street and num				wn, or Location of	Death	04	4c. County		1 1 a a a a a a a
Envoy I	Nursing	Home			P	ikesvil	le		Balt	imo	re
5. Social Security N	lumber 6.		7. Age (In yrs.		If Under 1 Months	Year If Under 24 Days Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, Y	éar)	9. Birth Cou	place (State or Foreign ntry)
214-12-: Usual Residence o			91	Yrs.				08 07	17		VA
10a. State	10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
MD	NA			Balt	imore						Y∑Yes 2 No
10e. Street and Nu					10f. Zip C	ode		10g	. Citizen of \	What Cou	ntry?
5113 Woo	olverto	n Ave				21215			U.	S.A	•
11. Marital Status		12. Was Deced		S. 13.	Was Decede	nt of Hispanic Origi Cuban, Mexican,	in? (Spe	cify Yes or No-			ican Indian,
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3 🗆 Widowed	4 Divorced	If Yes, Give Year or Da	e ites:		ILITES 2	XNO Specify:			Specify	v: B	lack
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17. Father's Name		st)				18. Mother	's Name	(First, Middle, Ma	iden Surnan	ne)	
George 1	Meachan	ı				Eliz	a D	avis			
19a. Informant's N	ame/Relationship	(Type. Print)		19b. Mail	ing Address (	Street and Number	or Rura	l Route Number, C	City or Town,	State, Zi	p Code)
Mary Jo	nes-Dau	ahter		5113	Wool	verton	Ave	, Balti	more	Md	21215
20a. Method of Dis	position			Place of Disp	osition (Name matory or oth	of			c. Location -		
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21. Signature of Fi			Ga	2	2. Name and	Address of Facility		1/09   0	wings	5 MI	lls, Md
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227 2271 1872	the disease or so	mplications that ca	used the deat			abash A				Mu	Approximate
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Cause (Disease or that initiated events	r injury	C									
resulting in death)		Due to (d	or as a conseq	uence of):							
		d									
IF FEMALE:		23c. If yes, outo	come of pregna	ancy					23d. Da	te of deliv	/erv
23b. Was deceder in the past 12		1 Live b	irth 2  Feta	I death 3	☐ Ectopic pre☐ Other (spe					onth	Day Year
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Part II. Other signi	l cant conditions	contributing to de	alli but not res	uning in the t	andenying cac	se giveri iii Fait i.					
temes	ntin							1 L Yes	2 🗌 No	3 ☐ Pro	bably 4 Unknown
Stan	e TV	Sacra	& D	cub	21 +:	VIcer	-	24a. Was an	24b.	Were aut	opsy findings available
	7			-4	3-1-3			autopsy	d?	death?	ompletion of cause of
OF Man and a service	read to madical					00. 51.	of Danie		No	1 □Yes	2∐No
25. Was case reference examiner?		Hospital:				Other		(Check only one)			
1  Yes 2		1 1	<del> </del>		ent 3 DOA	4 (A) INUI		ne 5 Residen		. , ,	ify)
27. Manner of Dea 1 Natural	5 Pending		of Injury h, <i>Day,</i> Year)	28b. Time of Injury	of 280	c. Injury at Work? 1 □ Yes 2 □ N		8d. Describe how	ınjury occur	red	
2 ☐ Accident 3 ☐ Suicide	investigat 6 ☐ Could not	ho	of Johnson					Of Location (C)	ot and Bloom	nor or D	ral Pauta Number
4 Homicide	determine	ed 28e. Place buildin	of Injury - At he ng, etc. <i>(Sp</i> ec <i>i</i> i	ome, tarm, st fy)	reet, factory, o	пісе	2	28f. Location (Stre City or Town,	er and Numt State)	er or Hui	ai Moute Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Directors: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

09-03359	3	Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contro					Black Inc							gible			
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Physi	cia	n/	Registrar 1. Decedent's Nan	ne (First, Middl	e,Last)		Cert		Deal				Date of Dea		100	7/	3. Time of Death
Medical Exa	min		Robert			Eug				ard			Month April 26, 2		Year	لــــــــــــــــــــــــــــــــــــــ	1615 hrs
			4a. Facility Name 3812 Penh	urst Avenu	e Apart	ment A			Baltir	more	Location of				County of		
Funer Directe			5. Social Security 217-98-	7527	6. Sex	7. 2 F	Age (In yrs. Ia		Monti	hs Day	_		. Date of Bi	23		Foreign	place (State or htry) VA
any		ŀ	Usual Residence of 10a. State	10b. County			10c. City,	Town or Loca	ation								10d. Inside City Limits
	nce.	5	MD	I	A		1	Balt	imor	е							1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	tified at o	흳	10e. Street and No. 3812 Pe		t Av	e			10f. Zij	p Code	1215		1	l0g. Citiz	en of Wha		•
h with	pe no	L	11. Marital Status		13		ent Ever in U.S		/as Deced	ent of Hi	spanic Orig	gin? ( Speci	fy Yes or No	p-	14. Race - White,		an Indian, Black,
after deatl	ner must	by Fun	1 X Never Marr 3 Widowed	4 Div	orced If Y	Yes es, Give Year Dates:	2X No	1	Yes 2	2X No	specify:		, , , ,		Specify:		.ack
hours 'natur	Exam		15. Decedent's E Elementary/Sec		cify only h	ighest grade of College (1-4		16a. Decede during				kind of work use retired)		16b. K	and of Busi	ness/In	dustry
0036 within 72 iene.	Medical	두다	12th gr	ade		na na	01 5+)	Con	stru	cti		orke				s E	mployers
1215-0036 d be filed within 7 ental Hygiene. arked other than	vent, the	Be	17. Father's Name James R	. Har	dy S	r.					Lor	is Ro			,		
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MOF Pages lent of int: If	r othe		1 X Burial 2	Cremation Other S		Removal from	State	Woodl		=)		5/1/0	9	Wo	odla	wn,	Md
Baltimore, permit. Pages I an Department of Hea Important: If ite			21. Signature of F			. 001		22. M	Name and	d Addres	s of Facility H We	st					
Physicia /Medic			23a Part I. Enter failure. List o	he disease, or nly one cause	on each	line.		Do not enter	the mode	Wab	<u>ash</u>	Ave,	Balt spiratory an				21215 Approximate Interval Between Onset and Death
Examin		4	Immediate Cause or condition result				cation and onsequence of		Jse							_	Deali
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executed an and	transit	<u> </u>	events resulting in		Due	e to (or as a co	onsequence of	):			•						
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of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by	d be de	ă b													No 3	Proba	ibly 4 🗸 Unknown
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of Vital Records, ng Physician: The law requir After this certificate has been s	funeral director, page	임	1 ✓ Yes 27. Manner of Dea	2 No		28a. Date of	Injury	28b. Time o			Jry at Work		d. Describe			4	Scene
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Division tall or Attendir is after death.	filled in by the	Certification:	3 Suicide	6 🗸 Cou	ld not be	28e. Place o	of Injury - At ho	ome, farm, st	reet, factor	y, office	building, et		or Town.	State)			al Route Number, City
D Hospital 24 hours Funeral	ly fille		4 Homicide 29a. Certifier	3	rmined	·	Single Fam		numer of at the	o timo d	loto and nic						, Baltimore, MD
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	completely	Medical	(Check only one) 2 ✓		miner: O		of my knowledge examination are										
<b>*</b> * * * *	8	Me	29b. Signature and	d title of contifi			λ		29		se number	1	-		Date signed	,	th, Day, Year)
			30. Name and add			•	of death (Item	,	Penn S	Street 1	Baltimore	e, MD 21	201				
	Sta	ate	31. Date filed (Mo				strar's Signatu	ire									
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DHMH 17 Rev 1/2001 OCME 2006

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 0535 HARRISON SYLVIA 22 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NIA JUHNS HUPKINS BAYVIEW MEDICAL CENTER BALTIMURE 8. Date of Birth (Month, Day, Year) 7 8 3 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 201 8 ΜD 76 217-24-3401 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4115 St. Clair Crossing 21213 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. I □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A 12th N/AHomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence James Raimev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3624 Dudley Avenue Baltimore, MD 21213 Joyce Cooper-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Crematory 4/27/09 Baltimore 4 Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Baltimore, MD 2120 I and Waner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 Hars HYPERCARBIA Due to (or as a consequence of): RESPIRATORY MUSCLE WEAKNESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery Vas decedent pregnant 3 DEctopic pregnancy the past 12 months? Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? 1 X Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or iteme 23a or 28a-f show amy highry or other traumatic event, Item Audical Examinar must be notified an once.

Baltimore, Maryland 21215-0036

use as the burial-transit sete has been signe page 2 should be certificete After this certification, I within 24 hours efter death. To the Funeret Director: A the filled in by

o the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical 2 Be Completed Certification: To

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	Part I	ı
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1		-

MALE:

1 XYes 2 □ No

27. Manner of Death

1 Natural

2 Accident

4 Thomicide

(Check only one)

3 Suicide

29a. Certifier

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

26. Place of Death (Check only one) Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Lorrel Brown MD 31. Date filed (Month, Day, Year)

RES-000

29d. Date signed (Month, Day, Year)

April 22, 2009

26 rom, Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENE BALTIMORE MO

State Registrar

completely

Medical

5 Pending

investigation

6 Could not be determined

32 Registrar's Signature back

		-	For State Registrar	State of Maryla		artment of F			giene Reg. No. 2 (	009	13705
	Physicia		1. Decedent's Name (First, Middle, Last)	Hillings				2. Date of De Month	ath Day	Year 2009	3. Time of Death
	/Medica Examine		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or		April h	26, 4c. Count	by of Death	7:30 A M
	Funeral Director		3469 Flannery Lane 5. Social Security Number 6. Sex 152-32-6870 1□1	7. Age (In yrs	s. last birthday) Yrs.	Bartimor If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ly, Year)		ace (State or Foreign try)
•	/aryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD NA	10c. C	City, Town or Lo					10	od. Inside City Limits  XX Yes 2 □ No
	with the N 3a or 28a-	Funeral Director	10e. Street and Number 3469 Flannery Lane		Dartimot	10f. Zip Code 21207			10g. Citizen of	What Count	ry?
9036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ant, It a Madical Examinat must be redified at			e. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Nas Decedent of H fYes, specify Cuba I∐Yes 21X No	ispanic Origin? (\$ in, Mexican, Puer Specify:	Epecify Yes or No to Rican, etc.)		ace - America ack, White, e	
RS I 21215-0036	led within 72 he tygiene. her than "natunt, Ire Medical	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12th Grade N	College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done of DO NOT use retired Ctronic Ass	during most of wo semble:		H	Dickin:	son
Beverly Fynes e, Maryland 2	2 should be file and Mental H is marked otl	To Be	17. Father's Name (First, Middle, Last) Brooks Kirkl  19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	Adelaide	me (First, Middle,	Bigelo	X.J	Code)
Dec: Bever	2 4 5 E		Walter L. Hyrnes - Hisb 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	and 20b.	3469 F	Jannery Lar sition (Name of natory or other place	ne Baltimon		-	- City or To	
D. Balti	permit. Departm Importa any Inju	-	Signature of Funeral Service Licensee	m. alyl	w 92	Name and Address 200 Liberty	ss of FacilityWy1	ie Funeral	Home PA	of Bal	timore,County
4	Physician /Medical Examiner	10	23a. Pard. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the dea cause on each line.  Due to (or as a conse	14/	_	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conse							
0. Box 6	ath certinattending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 [	Ectopic pregnanc Other (specify)	у			ate of delive Month	ry Day Year
rds, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contr	ibuting to death but not re	esulting in the u	nderlying cause give	en in Part I.		obacco use coi Yes 2 ☐ No		e cause of death?
al Reco	sician: The law re certificate has be irector, page 2 sho	Completed	25. Was case referred to medical					1 □ Yes	osy ormed? No	o. Were autop prior to con death? 1 □ Yes	osy findings available inpletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page?	Certification: To Be	evaminer?	spital: 1 Inpatient 2 [ 28a. Date of Injury (Month. Pay, Year)  28e. Place of Injury - At building, etc. (Spec	28b. Time of Injury	28c. Injur Work	er: 4 □ Nursing I y at		dence 6 🗆 O	ırred	()  I Route Number,
j J	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier Certifying Physic	cian: To the best of my ki	nowledge, deat			e, and due to the	cause(s) and r		
Ŋ	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	77	29c. Licens	-	La la la la la la la la la la la la la la	29d. Date sign		
			30. Name and address of person who com				(8/a	ا ا م	TDFU	26,	2009
	Stat Registra		31. Date filed (Month, Day, Year)  APR 2 9 2009	32. Aegistrar's Sign	nature A.	und	۵/,	4/1	$> \rho$		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11:15 A^M Thomas Christopher Hogan April 24 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 11754 South Laurel Drive, #2B Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 55 1, 1954 Director Ohio 032-44-2327 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 1 ∐Yes 2√∑No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11754 South Laurel Drive, 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes ②☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify þ 3 ☐ Widowed 4 🖾 Divorced "natural" Completed 7 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Community Resource Advisor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Walter Hogan Suzanne Stanbro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) of Health of Item 27 i Anna Christina Hogan/Daughter 389 West Side Drive, Apt. 201, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4/28/2009 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, 20707 M01103 Approximate Interval Between Onset and Death 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate (Final disease or condition resulting in death) Physician Prostate Cancer 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 🎇 No ous after death.

erai Director: After this certifical filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funerail 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of pertific 29d. Date signed (Month, Day, Year) April 28, 2009 30. Name and address on who completed cause of death (Item 23a) (Type, Print) Mark Sivieri 9101 Cherry Lane, #205, Laurel, MD 20707 31. Date filed (Month, Day, Year) APR 2 9 2009 . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location 4a Fecility Name (If not institution, give street end number) Examiner Mei VIEV If Under 24 Hrs 9 Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Social Security Number 6. Sex **Funeral** Days Months 1□M 20 F 217-20-5489 Usuel Residence of Decedent Yrs. Virginia Director Pages 1 end 2 should be filed within 72 hours after deeth with the Meryland tent of Health end Mentel Hygiene. Int: If item 27 is marked other than "netural", or items 23a or 28a-f show 10d. Inside City Limits 10a. Stete 10b County 10c. City, Town or Location treumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director Itimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race 11. Maritel Status 1 Never Merried 2 Married 1 Yes 2 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Etementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) ones Hmanda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: if item 27 20c. Location Lity or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph L. Rus 2222 W. Nort 21. Signature of Funeral Service Licensee Home Pu orth tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Enter the disease, or comptical or heart failure. List only one **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be exacuted for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 4 → Unknown 1 Yes 2 No ete hes been signed page 2 should be de Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2.XNo 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA Medicai Certification: To 1 Yes 2 No 25 ER/Outpatient 28b. Time of Injury 28d. Describe how injury occurred Date of tnjury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 1 SNaturel 5 Pending investigation 2 No 1 ☐ Yes 2 Accident Director 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter To the Funerel Direc efter 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 20028486

Registrar

State

Backs

Johns

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J

APR 29 2009

31. Date fited (Month, Day, Year)

09-03154	
Marvin Harne	

Marv	in Harpe		State of	Maryland / Departmer	nt of Health te of Death			200	19 1370
	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Certificat	e or Dearr		Reg. 2. Date of Death		3. Time of Death
Med	ical Exami	ner	Marvin H	arpe			April 20, 200		1120 hrs
			4a. Facility Name (if not institution, give st Johns Hopkins Hospital	reet and humber)	4b. City, To Baltim	own, or Location of Death	1	4c. County of Deat	A
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthd	lay) If Under	r 1 Year   If Under 24Hrs		MM/DD/YYYY) 9. Bi	
	Director		217-68-000K 1XM	2 F 53	Yrs. Months	Days Hours Mir	Jan.8		ountry) Md
	any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	*	Ļ	Md N/A	Bal	timo	050			1 Yes 2 No
	vfaryland 28a-f show d at once.	Director	10e. Street and Number	1 1	10f. Zip	Code	109.	Citizen of What Cou	untry?
	th the last or notified	ä	2433 W. Lafa	yette Ave.	2	nt of Hispanic Origin? ( S	Procify Ves or No-	USF	rican Indian, Black,
	eath wi	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces?	If Yes, specify	y Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	figur maint, Electry
	after da al., or iner m	by Fr	3 Widowed 4 Divorced If	Yes, Give Year Dates:		/		Specify: B	lack
	hours 'natur Exami	ted k	15. Decedent's Education (Specify only Elementary/Secondary (0-12)			Occupation (Give kind of king life. DO NOT use re		6b. Kind of Business	/Industry
	336 thin 72 ne. than '	Completed	GED	College (14 of 51)	me I	mpraver	rent	Self-E	mployed
	5-00 iled wi Hygier Jother the M		17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, Ma	iden Surname)	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	o Be	19a. Informant's Name/Relationship (Typ	Print) (Faller) 19b.	Mailing Address	(Street and Number or	Rural Route Number	er, City or Town, St	te, Zip Code)
	MD 3 d 2 shou lith and l n 27 is n		Mr. Robert Ho	arpe Sr. 124	433 W	Lataget	te Ave	· Balto.	Md. 21216
2	s I and street Healt If item		20a. Method of Disposition  1 X Burial 2 Cremation 3		Disposition (Namery or other place)	1 1	/ /	20c. Location - City o	or Town, State
	Baltimore, bermit. Pages I ar Department of Her important: If ite		4 Donation 5 Other Specify:	1 1-01270		Cemelecul	27/2009	Balto	. Ivia.
	Baltil permit. Departm Importa injury o		21. Signature of Funeral Service Licens	Ir a.	22. Name and Joseph	1 1 1	unegal	Home, Pit	1216
	Physician		23a. Par I. Enter the disease or complication. List only one cause on each	ations that caused the death. Do not	enter the mode o	of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
	/Medical xaminer		Immediate Cause (Final disease a	Fungal Infect	ion	ı compiled	cing syst	<u> </u>	Death
			h	e to (or as a consequence of):					
		iner	cause. Enter Underlying Cause	e to (or as a consequence of):					
	_ +	Examiner	(Disease or injury that initiated	e to (or as a consequence of):					
	0,  be executed sician and burial - transit	dical E	d	AMENDED 23a,27,28a	-f per m	1e, g890 4-30	)_09 vt		<del> </del>
	50, te be en nysician burial		IF FEMALE:	23c. If yes, outcome of pregnancy	6891 5/	7/09 TT		23d. Date of deliv	ery
	6876( certificate nding physise as the b	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	3 Ectopic pregi	nancy	Month	Day Year
	of Vital Records, P.O. Box 6876( ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the b	Physician/Me	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5 9 Unknown	Other (Spe	cify)			
	O. Enat the ed by the etachec		Part II. Other significant conditions	ontributing to death but not resulting	in the underlying	g cause given in Part I.			to the cause of death?
	of Vital Records, P.O. is Physician: The law requires that the Note this certificate has been signed by neral director, page 2 should be detach neral director, page 2 should be detach	ed by	\				1 Yes 24a. Was ar		autopsy findings available
	cord law rec has bee 2 shou	Completed					autops: perform	y prior t ned? death	o completion of cause of ?
	Re( i: The ifficate rr, page	ပ္ပ	25. Was case referred to medical			26.Place of Death (Chec	1 Yes 2	✓ No 1	Yes 2 No
	Sion of Vital Attending Physician: r death. ector: After this certif by the funeral director,	o Be		spital: 1 🗸 Inpatient 2 ER/Ou		100		tesidence 6 Ot	ner:
	ing Ph After t Suneral	ī.	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	ime of Injury	28c. Injury at Work?		ow injury occurred	
	Division tal or Attendin safter death.	catic	2 Accident Investigation	28e Place of Injury - At home far	cnown	1 Yes 2 X No	unknowi 28f, Location (St		Rural Route Number, City
11	Divi	Certification:	3 Suicide 6 X Could not be determined	(Specify) unknown	m, 34004, 140tor)	y, ombo banamy, oto	or Town, Sta unknow	ate)	
V	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	al C	29a. Certifier 1 Certifying Physician	n: To the best of my knowledge, dear	th occurred at the	e time, date and place, a	nd due to the cause	(s) and manner as s	tated.
	To the within To the comple	Medical	one) 2 Medical Examiner: 0	On the basis of examination and/or in nd manner stated.		c. License number	at the time, date a	29d. Date signed (	
		2	235. Signature and the of certifier	PO 10 0	25	O.C.M.E.		April 21, 2009	,
			30. Name and address of person who co						
			<u> </u>		Penn Street,	Baltimore, MD 212	201		
	S Regis	tate trar	0 0 0000	2. Registrar's Signature	arked				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8890 4/29/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 22, 2009 **Physician** Roy Joseph Jackson 5:45P April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 608 Cromwell-Whye Lane Monkton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) **Funeral** Months Days Hours **№** M 2 🗆 F Mar. 22,1933 Maryland 216-30-0858 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Extractment be rediffical an once. 1 ☐ Yes ※ ☐ No Maryland Monkton Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21111 608 Cromwell-Whye Lane Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: þ 3 Nidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Auto Mechanic Exxon 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Levere Harvie Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21111 Monkton, Maryland 20c. Location - City of Town, State 609 Cromwell-Whye Lane Denise Boyd/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition St.Luke's U.M. Church Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hereford, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Fundamental Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) COPS **Physician** /Medical Due to (or as a consequence of): **Examiner** 14 MIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Rencie attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, NOTUR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been się r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 ☑No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 27. Man of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel hugh Collector, MD 35 E. Padonia Rd Timonium, MD 21093 82. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2009 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 2. Date of Death Month Day Year

Physiciar /Medica		AUDRET ILE	AN	JOHNS	TON			Month	Day Year 200	9 9 45AM	
Examine	r	4a. Facility Name (If not institution, give s Carroll Hospital		)	4b.	City, Town, or Locat Westmins			4c. County of Dea		
uneral rector		215-34-2234	M 2∭ F 7. Aç	ge (In yrs. last birt 72	thday) If U Yrs. Mor	nder 1 Year If Ur oths Days Hou	ire Min	8. Date of Birth (Month, Day, Ye April 28,	9. Bir 1936	thplace (State or Foreigr ountry) MD	
a-f show		Usual Residence of Decedent	L	10c. City, Town	n or Location	Union Br	ridge			10d. Inside City Limits 1 ∭ Yes 2 ☐ No	
23a or 28a	5 ∣	10e. Street and Number 26 S. Main Street	· · · · · · · · · · · · · · · · · · ·		10	f. Zip Code 21791	-	10g.	Citizen of What Co USA	ountry?	
S 1		11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Ye ar or Dates:	}		Decedent of Hispanio specify Cuban, Me es 2 <b>X</b> No <i>Sp</i> e		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
Market Market	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or		Decedent's (Give kind of life. DO NO Homen	Usual Occupation of work done during OT use retired) naker	most of worki	ng 16t	Domesti	·	
even even	lo Be C	17. Father's Name (First, Middle, Last)  Alfred Winter Duvall  19a. Informant's Name/Relationship (Type. Print)  18. Mother's Name (First, Middle, Maiden Surname)  Amy Moxley  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
- = I	115	Mr. David C. Johns1  20a. Method of Disposition  W☐ Burial 2 ☐ Cremation 3 ☐ Re	ton, Jr.	(Son) 30	014 Be	(Name of or other place)	Baltim	ore, MD 2	21227 : Location - City or	Town, State	
any Injury or other once.	I	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Lake V:		em. Park HT ^d fffffffff Dox 195 Sy	5/1/2 Afility HOME kesvil	2009   Sy E & CHAPEI 1e, MD 2	rkesville 784.	, MD	
	Ĭ	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	ine.	em ( of): wash	mode of dying, such	,			Approximate Interval Between Onset and Death	
for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		ppic pregnancy er (specify)			23d. Date of de Month	elivery Day Year	
pe d	2	Part II. Other significant conditions con		iting to death but not resulting in the underlying cause given in Part			Part I.			o the cause of death? Probably 4 🗓 Onknown	
page 2	Completed	Acute Re	nal fa	nluve	_			24a. Was an autopsy performed	prior to death?		
this of	0	IL res 2LL	ospital:		utpatient 3[	DOA Other: 4	☐ Nursing Ho	me 5 Residenc		ecify)	
eral Director: After th filled in by the funeral	Certification:	27. Manner of Death  1 Matural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be determined	28a. Date of Inj (Month, Da 28e. Place of In building, e	ay, Year) 280. In the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	Time of njury M rm, street, fa		2 🗆 No	28d. Describe how in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	at and Number or F	Bural Route Number,	
	Medical Ce	29a. Certifier (Check only one)  1 ** Certifying Phys 2   Medical Examination	ilcian: To the best ner: On the basis and manner si	of examination an	e, death occi nd/or investig	urred at the time, da lation, in my opinion	ite and place, , death occur	and due to the causered at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)	
dwoo	Me	29b. Signature and title of certifier	& les		<u> </u>	29c. License num			Date signed (Mon		
; ¥ 8		Soundful 30. Name and address of person who co		death (Item 23a) (	(Type, Print)	1295	02 M	ŋ	4/271		

State Registrar

For State Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylar		rtificate of D			Reg. No.	0.9	13711
	Physicia	an	1. Decedent's Name (First, Middle, I			7.0		2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medic		Samuel 4a. Facility Name (If not institution, g	Willar give street and number)	ď	Jon 4b. City, Town, or	Location of Death	04	26 2 4c. County	009 of Death	11:45a.
1			2334 Sidney A		look birtheloud	Baltimo	ore If Under 24 Hrs.	8. Date of Birt	h	9 Rirthr	place (State or Foreign
	Funeral Director		5. Social Security Number 231-05-0473 Usual Residence of Decedent	Sex 7. Age (In yrs. X□ M 2□ F	Yrs.	Months Days	Hours Min.	07 20	y, Year)	Cour	va
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo					1	0d. Inside City Limits
	e Mar Ba-f st	ctor	MD NA		Balti	,					1X Yes 2 □ No
	a or 2	Funeral Director	10e. Street and Number			10f. Zip Code	1230		10g. Citizen of	• S • A	
	death ms 23	nera	2334 Sidney Av	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of His If Yes, specify Cubar		pecify Yes or No		ce - Americ	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. It is a few must be notified a once.	þ	1 ☐ Never Married 2 【文 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	i	1 ⊡Yes 2 <b>X</b> ⊡No	Specify:	Thoan, etc./	Specia		lack
2-0	"natur	letec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of work	ting	16b. Kind of B	Business/In	dustry
72	within jiene. r than	Completed	Elementary/Secondary (0-12)  10th grade	College (1-4or 5+) <b>na</b>		rchant M			U.S	. Li	nes
nd	e filed tal Hyg 1 othe	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Surnai	^{me)} Un	known
yla	iould by Ment	ဥ	Willard Jones	(T. 5) ()	405 44-11	ng Address (Street a	and Number or Du	ral Pauta Mumb	ar City or Town	State Zir	o Codo)
Maryland	nd 2 sh ulth and 27 is n r traun		19a. Informant's Name/Relationship Helen Jones-Wi			sidney					
ore,	es 1 ar of Hea fitem		20a. Method of Disposition	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date	20c. Location	- City or To	own, State
Baltimore,	. Page tment tant: It iury ο		1√ Burial 2 ☐ Cremation 3 4☐ Donation 5 ☐ Other (Spe	cify) Ki		morial E		1/2009	Woodl	awn,	Md
Baj	permit Depar Impor any in	9 19	21. Sgrature of Funeral Service Li	S. Keke	Ma 43	2. Name and Addres arch F/H 300 Wabas	West sh_Ave,			Md	21215
			23a. Part 1. Enter the disease, or co shock, or heart fullure. List or	implications that caused the dea ily one cause on each line.	th. Do not en	ter the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
The same	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CHror  Due to (or as a conse		35TV U.CT	IVE PL	al mona	14 G13	EASE	
	Examiner		Constant list conditions	b.	9441100 01/1						
W	ed sit	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of).						
r	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					:	
68760,	rtificate be executed ng physician and as the burial-transit	/ledical		d							
x 68	certifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregr	nancy				004 D	-16 dallin	
Вох	eath c attend	cian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	☐ Ectopic pregnancy ☐ Other (specify)	/			ate of deliv Ionth	Pery Day Year
P.0.	it the d by the tached	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown							
ls,	res tha	ğ	Part II. Other significant condition	s contributing to death but not re-			en in Part I.		obacco use cor Yes 2 □ No	ntribute to t 3□ Pro	the cause of death?
Sorc	requi been s	Completed	0 0 1 1 0 0	TC INCOST	000	110-		24a. Was			opsy findings available
Bec	he law te has age 2 s	dmc						auto perfo		prior to co death? 1 \( \sum Yes	ompletion of cause of
ita	sian: T	Be C	25. Was case referred to medical examiner?				26. Place of Dea			10163	2 (3110
of <	Physic this ce al dire	၉	1  Yes 2  10 10	Hospital: 1 Inpatient 2	<del></del>		4 Li Nuising H	ome 5 Resi			fy)
on (	iding P th. After funer	tion:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of finjury	Work	yat (? Yes 2 □ No	28d. Describe	how injury occu	irred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Certification:	3 Suicide 6 Could no determin	t be 28e Place of Injury - At I	home, farm, st	treet, factory, office		28f. Location ( City or To		ber or Rur	al Route Number,
り	Hospita 24 hours Funeral etely filled	edical C		Physician: To the best of my kr xaminer: On the basis of examir and manner stated.							
J	To the within To the compl	Me	29b. Signature and title of certifier	<b>.</b>		29c. License			29d. Date sign		
				mmo		D3	5102		April	27,	2009
				ho completed cause of death (Ite M - D . 5901	em 23a) (Type	, Print) M (It AV	1155tv	ud Bri	Limor	m	MYLAND
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature		·		1110		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 27, 2009 Day am **Physician** Margaret JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2/1 Gienera Date of Birth (Month, Day, Birthplace (State or Foreign Country) In vrs. last birthday 8. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 F Yrs MD **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. MD Baltimone 1XYes 2 □ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA Road genvood Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married / MRGWLT JUNSP Baltimore Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Back Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Health Care Elementary/Secondary (0-12) CMA grade 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tillor Mildred Winite Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Road Baltin lone, MD21215 Daughter 3410 Edgenood enae 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State Owings Mills, MD Garrison Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee mucho C. Greene Funoral sycs Kandalistown MD 2113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart sailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed ancer sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performed? yes 20No certificate 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Fxamilyer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signa 09 cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 904 **Physician** racie 2009 M Johnson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Invorsity of Maryland Medical Contex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–06–1976 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2 1 F WASHINGTON, DC Director 579-82-7737 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Director PRINCE GEORGES TEMPLE HILLS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 U.S.A. 6512 BEECHWOOD DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 □Yes 2 X No <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) TEACHER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be. Department of Health and Mental I. Important: If Item 27 is martany or other 7. Be WOODSON SHTRLEY ALFRED W. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LYNN DONNELL JOHNSON - HUSBAND 62 JOYCETON TERRACE, UPPER MARLBORO, MD 20772 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HERITAGE MEMORIAL CEM. 5/2/2009 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Address of Facility RONALD TAYLOR 10583 MIDDLEPORT LANE, WHITE 23a. Part I. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 22. Name and Address of FacilityRONALD TAYLOR II FUNERAL HOME 10583 MIDDLEPORT LANE, WHITE PLAINS, MD 20695 Immediate Cause (Final Lactic acidosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bilateral, diffuse pneumonia Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Neutropenia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 X No 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Myes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, hours after death. within 24 hours after used.

To the Funeral Director Hospital

use as attending properties of the second been signed by the should be detached cate has l page 2 s funeral director,

28a-f show

death with

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Wedical Examiner must be notified a

2 should be filed within 72 hours after cond Mental Hygiene.
is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

To the

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

5 Amber Marshall Paca St

and manner stated.

29a. Certifier (Check only one)

09-03250 Bryan Kubic, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #45 Bero Maryand #Department of Health and Mental Hygiene

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		For State Registrar	Certificate of		a Works		g. No. 201	J9   37
Physici	an/	Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
Medical Exami		Bryan Kubic, Jr.				April 23, 20	4c. County of Death	0326 hrs
		4a. Facility Name (if not institution, give street and number)  Anne Arundel Medical Center		4b. City, Town, or	Annapol		Anne Arundel	
			yrs. last birthday)	If Under 1 Yea				thplace (State or Foreign
Funeral Director		165-68-2318 1XM 2F 2		Months Day		_	Co	untry) nnsylvania
any	-	Usual Residence of Decedent  10a, State 10b, County 10c.	. City, Town or Local	tion			-	10d. Inside City Limits
* .	_	MD Anne Arundel A	nnapolis					1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	ä	803 Latchmere Court #203		21 401				SA
15-0036 filed within 72 hours after death with the Maryland I Hygiene. do other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Ever Armed Forces? 1 X Yes 2	No If Y	as Decedent of Hi Yes, specify Cuba	n, Mexican, Puert		White, etc.	ican Indian, Black,
s after ral",	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No		work done	Specify: Wh:	
2 hour "natu Exan	ted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life			Top. Kind of Eddiness,	industry
5-0036 led within 72 hours at Hygiene. I other than "natural the Medical Examin	Completed	12		Soldie	r		ARMY	
21215-0036 und be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle, Last)		DOLUTO	18.Mother's Nam	ne (First, Middle, N	Maiden Surname)	
2121! uld be fil Mental F marked	Be	Bryan Kubic, Sr.				Gene Gre		
ID 21 should and Me 27 is ma	은	19a. Informant's Name/Relationship (Type, Print )					nber, City or Town, State	e, Zip Code)
e, MD 1 and 2 sho Health and item 27 is		Renee G. Kubic / mother  20a. Method of Disposition	20b. Place of Dispo	ern Driv		nester,	PA 17345	Town, State
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State	crematory or o	ther place)	·	/20/2000	Vords Do	nnaultania
t. Pag tment rtant		4 Conation 5 Other Specify:	Cremation				York, Pe eral Home	IIISYIVAIIIA
Baltimore permit. Pages I Department of I Important: If injury or other		21. Signature of Funeral Service Licensee		512 NW Cr			e, MD 2071	5
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/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot V	Vound of Head					Death
xaminer		or condition resulting in death) Due to (or as a conseque						
	ᅵᇷ	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a conseque	ence of):					
	Examiner	Course Enter Underlying Cause C.						
ecuted and transit		events resulting in death) Last  Due to (or as a conseque	ence or):			<del></del>		
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760, ficate be g physic the buri		IF FEMALE: 23b. Was decedent pregnant in the	_	-1-1 J11 3	Estopic pres	nancy	23d. Date of deliver	y Day Year
Box 687 death certificate the attending of the ast	sician/	past 12 months?	o of donth	etal death 3 other (Specify)	Ectopic preg	папсу	Month	Day Teal
BO) e death the att	Physi	1 Yes 2 No 9 Unknown g Unknown						
P.O. E es that the digned by the	by Pi	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause	given in Part I.		obacco use contribute to s 2 ✓ No 3 Pro	
S, P.( uires that n signed Id be deta	ed b					-		utopsy findings available
ords w requir	Completed					24a. Was	osy prior to	completion of cause of
Record The la	E					1 Yes		es 2 No
ital Recions: The scertificate rector, page	Be	25. Was case referred to medical examiner?		26.Plac	e of Death (Chec			
Yysic Physic rthis	일	1 ✓ Yes 2 No	2 CR/Outpatier		Other Nurs		Residence 6 Othe	Эг: 
n of ding Ph.  After t After t		27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month Day Year)  Apr 23, 2009	28b. Time of 0059 hrs		ury at Work? Yes 2 ✔ No	Subject sho	how injury occurred ot self	
ivision Lor Attend after death. Director:	cati	2 Accident Investigation	- At home, farm, stre			28f. Location (	Street and Number or R	ural Route Number, City
Division of Vital Records, pinal or Attending Physician: The law requiremental earth. Ceral Director: After this certificate has been siftled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-F		, ·, , - · · · ·	3.	or Town, S		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Co	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examinar	nowledge, death occi	urred at the time, of ation, in my opinion	date and place, a	nd due to the caused at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
To To con	Mec	29b. Signature and title of certifier		29c. Licer	se number		29d. Date signed (M	onth, Day, Year)
		Panal, Prestland no	1	0.0	.M.E.		April 24, 2009	
	i I	· arguer purpey, 110	h (Ham 22a)					
1		30. Name and address of person who completed cause of death	n (item 23a)					
171		30. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical 31. Date filed (Month, Day, Year) 32. Fegistrar's S	Examiner 1	11 Penn Stre	et, Baltimore,	MD 21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:56 5, 2009 <u> April</u> ARLENE FRANCES KANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 163 Meadow Road Pasadena Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Hours Months Days 1□ M 2 F 74 Yrs. 02/10/1935 Maryland 213-34-9744 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examirar must be routified at 28a-f shov 1 ☐ Yes 2 PNo Directo MD Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. 163 Meadow Road Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 2 3 ☐ Widowed 4 M Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Ment Mary C. McLaughin ၉ Edward James Buker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5949 Elk Forest Court, Elkridge, MD 21075 Jeffrey M. Kane / Son permit. Pages 1 a
Department of He
Important: If item
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/27/09 | Baltimore, MD 22. Name and Address of Facility G.J. Gonce Funeral Home, 21. Signature of Juneral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Atherosclerotic Cardiac Disease Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria spital or Attending Physician: The law requires that the death certificate be cours after death.

neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

APR 49

Dr. Michael
31. Date filed (Month, Day, Year)

865**1** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garahy

F

D0021703

04/27/2009

Ft. Smallwood Rd., Ste 1, Pasadena, MD 21122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 200 Month **Physician** KORONA APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Northwest Hospital Center 8. Date of Birth (Month, Day, Sept 1, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days ^{Year)} 1917 1 □ M 2 🖓 F Yrs. 203-28-0168 91 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Carrol1 Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 15 Gaither Manor Drive Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 □XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Catherine Beatty Michael Moriarty ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John E. Korona (Son) 6500 Ridenour Way E. #2A Eldersburg, MD 21784 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 4/30/09 Marriottsville, MD 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 Duar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2HEIMER'S DEMENTIA /Medical Due to (or as a consequence of): Examiner BILLIRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an this certificate has all director, page 2 s autopsy 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified mehlam.o D41410 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1061H0ER

Registrar
DHMH 17 Rev 1/2001

State

RANCHISTOWN

SPITAL.

. Registrar's Signature

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MORTHYNEST

7 2 9 2009

31. Date filed (Month

		-	State of Mary  1 - State Registrar		epartment of Hea Certificate of Dea			giene Reg. No. 2 / / / /	9 13717		
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4	23a (	ral	1131 William Street		2123			U.S.A.  Id. Race - American Indian,			
050	al", or items	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of Hispar If Yes, spedfy Cuban, M 1 □Yes 2 🖾 No Sp	nic Origin? (Spe lexican, Puerto F pe <i>cify:</i>	city Yes or No- Rican, etc.)				
3-003b	penim. Tages I and a Subus demonstration in the manyana Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occupation Give kind of work done during	n na most of workin	na I	16b. Kind of Busines	s/Industry		
7		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	- //	fe. DO NOT use retired) ide	<i>g</i>		Hospita	1		
17 D		ပို	17. Father's Name (First, Middle, Last)	1.		Mother's Name	(First, Middle,	Maiden Surname)			
yland	Aental Aental rked o	To Be	Noble Gardno	er		Beu1	lah E.	Smith			
Mary	and N is ma suma		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street and I						
ຂຸ້.	Health Health Sm 27 Sm 27 Ther to	1 %	Kay Maurer / Daughter  20a, Method of Disposition 2		31 William St.		Balti	20c. Location - City of	rland 21230		
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Baltimor	permit. I Departm Importar any injur once.	Ì	21. Signature of Funeral Service Licensee		22. Name and Address of	·		eral Servi			
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O. Box	to the nospital or Attending Prysician: The law requires that the beath certification by the Europers and the standards.  To the Puneral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of p. 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year		
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1	within To the compli	Me	29b. Signature and title of certifier		29c. License nui	ımber		29d. Date signed (Mo			
			> / Thamame, ms.		D17-	753		4-25	- 2009		
	13		30. Name and address of person who completed cause of death	(Item 23a) (T	/pe, Print)	01 - 1 - 1	20	2 2122	_		
	\ Sta	to	K. S. DHARMASENA, M.D. 37.  31. Date filed (Month, Day, Year)  32. Registrar's	Signature	IFF St. BA	TLIIMO	E,M	ツ よしょう	>		
	Registr		30. Name and address of person who completed cause of death $K: S: DHARMAS = NA, M: D: 37.$ 31. Date filed (Month, Day, Year) 32. Registrar's 33.	1. bo	ald						
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**ORIGINAL** 

Physiclan /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed

neral Director: / within 24 hours a Medical

Division or Vital Records, P.O. Box 68760,

disease or condition	000	13								
resulting in death)	Due to (or as a consec	uence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe or injury that initiated events	Due to (or as a consec	quence of):								
resulting in death) Last	Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3 Ectopic pre			23d. Date of deli Month	very Day Year				
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying ca	use given in Part I.		o use contribute to	the cause of death?				
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of				
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inpatient 2 □	]ER/Outpatient 3 □ DO	Othor	ath (Check only one)  Home 5 ☐ Residence	6 □Other (Spec	cify)				
27. Manno of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory	office	28f. Location (Street City or Town, Sta		ral Route Number,				
	sician: To the best of my kni iner: On the basis of examinated and manner stated.									
29b. Signature and title of certifier	Ono	29c	8781365	29d. [ 4]	Date signed (Month	n, Day, Year)				
30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type,/Print)	GR, eene St	leet BALLI	more, MI	21201				

State Registrar 31. Date filed (Month, Day, Year)

APR 29

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Audrey Dorethea Linton 23:45?M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mos N/Ao.tal Bestronge 44 Batmar C If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 XF Director 216-28-2553 Usual Residence of Decedent Feb. 25, 1929 Mary Land 10a State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Gwynn Oak 1 ☐Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 3808 Byfield Road Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes XXNo Specify: 2 Specify: 3√ Widowed 4 □ Divorced "natural" Completed item 27 is marked other than "nature other traumatic event, the "secont 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Self Employed 10th grade 18. Mother's Name (First, Middle, Maiden Surname) Ella Baylor 17. Father's Name (First, Middle, Last) Be Clem Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 i of Health i Nena Roberson/Daughter 3808 Byfield Road Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 5 1 → Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Stevenson AME Church 260m. Sparks, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris FuneralHome 21. Signature of Euneral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part . Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or hear, allure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Caus Final disease or condition resulting in death) Physician 5 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be execute been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl 24a. Was an autopsy performed 2 No Division of Vital 1 Xyes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Natural Accident 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

APR 29

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4c per MD 8891 5/7/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 04-26-2009 1200 PM Ann Alatis Loucas /Medical Harford 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 21047 1801 Brickhouse Lane Fallston 8. Date of Birth (Month, Day, Year) 03-01-1933 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🛣 F 76 WV 235-48-7827 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expression must be notified at 1 ☐ Yes 2 🔀 No Director MD Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 USA 1801 Brickhouse Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 □Yes 2 📉 No Specify White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Galanos ပ္ Efstathios Alatis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. Fallston, MD 21047 1801 Brickhouse Lane Michael Loucas (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-01-2009 St. Demetrios Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Lig Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Non 50 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760, P.0. the detached cate has been signed by page 2 should be detach Division of Vital Records, The certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director.

death with the Maryland

filed within 72 hours after

be

Pages 1 and 2 should

Health and Mental Hygidem 27 Is marked other

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of cortil

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

PHYSZCEAN

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATMOOD ROAD SULTRELOO BELAZE HOSTOR 602 strar's Signature

09-03256 Harry Lai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 13721

		- For State		Ce	ertificate o	f Death					eg. No.	lon W	0 7 1 0 7 1
Physicia ledical Examin	n/ 📑	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year									Year	3. Time of Death 0832 hrs	
	4	4a. Facility Name (if not institution 21 Wall Street	on, give street and n	umber)		4b. City, Tov Rockvil		ocation of	Death			nty of Deat gomery	th
Funeral Director		5. Social Security Number 133–16–6735	6. Sex	7. Age (In yrs.	. last birthday)	If Under Months	1 Year Days	If Under Hours	4.6-		7th (MM/DD/Y	Forei	irthplace (State or ign ountry) China
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours afterent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", rother traumatic event, the Medical Examiner.	To Be Completed by Funeral Director	10e. Street and Number  21 Wall Street  11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)  17. Father's Name (First, Middle Sunny Lai 19a. Informant's Name/Relations Beitske B. W. 20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	gomery  12. 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O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un	Due to (or as d.  AMENDEI  23c. If ye  1 Liv. 4 Pre	s, outcome of p	regnancy	Fetal death Other (Spec	3 [ ify)	Ectopic	: pregnai		Мо	ate of deliv	Day Year
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the cours after death.  neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached.	Certification: To Be Completed by	2 Accident Inv 3 Suicide 6 Co- 4 Homicide det	Hospital: 1  28a. Da (Mo estigation uld not be termined  28e. P (Special)	Inpatient 2 ate of Injury onth, Day, Yeer) lace of Injury - A	ER/Outpatie 28b. Time of	ent 3 Do	26.Place DA   18c. Injur 1 Y	of Death Other4 Try at Work Yes 2 uilding, et	(Check of Nursin Property of No No No No No No No No No No No No No	24a. Wa au' pye only one) g Home 5 28d. Descrit 28f. Location or Towr	Yes 2 No as an lopsy formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed? formed?	o 3 F  24b. Were prior death  1  e 6 O O Occurred  Number or	Yes 2 No ther: Scene Rural Route Number, City
To the Hos within 24 h To the Fur completely	29b. Signature and title of certifier  O.C.M.E									umber 29d. Date sign			o the cause(s) (Month, Day, Year)
101		_	tant Medical Ex	kaminer 1	11 Penn Str			MD 212	201				
Si Regis	tate		9 2009 32	Registrar's Sig	nature .	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April  $2^{\text{Pay}}$ 2009 Physician 5:45 Larkin Elizabeth Μ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Kensington Kensington Park 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days 1 □ M 2 🛛 F 16, New York 85 July 104-18-6778 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20817 6205 Stoneham Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: \$ 3 X Widowed 4 ☐ Divorced "natural" Completed er than "natur, 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hyglene. 27 is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine H. Madigan Albert E. Cabot ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 6205 Stoneham Road, Bethesda, Maryland 20817 Catherine C. Lynch / Sister item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 28, April 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department or Important: If any injury or once. <u>~</u> ŏ Bethesda, Maryland Montgomery Crematorium, Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 letto Dania M01305 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive Heart Failure physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Hypertension attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □ Yes 2 lono 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> 10 v State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$200 Tower Oaks Blvd., Suite 110, Rockville, Maryland 20852 Ajay Reddy, M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53691

29d. Date signed (Month, Day, Year)

April 27, 2009

and manner stated.

Year) 31. Date filed (Month, Day, APR 29 2009

29a. Certifier

(Check only one)

29b. Signature and title of derti

Medical

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Doris Mover Margaret 2009 Apri1 5:05a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Lorien Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Min. Months Days Hours 1 □ M 2 ⋤ F 217-14-2159 83 Director Sept 1 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, I'm Modified Att Columbia MD Howard 1 □Yes 2 ŪNo Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21044 USA 5675 Columbia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ WNo Specify: white Specify: و م 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Reisinger Agnes Caldwell ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5675 Columbia Rd. #303, Columbia, MD 21044 Eugene D. Moyer (spouse) 20a. Method of Disposition
1 ☐ Burial 2 🖒 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State All-County Cremation 4/28/2009 Svkesville. MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Harght of P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oronar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir burial-trar Due to (or as a consequence of) physician sthe burial Physician/Medical / the attending phohed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 T Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ donknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? 1 □ Yes 2 ☑ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1∐Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Division of Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

Pages 1

law requires that the death certificate be executed and peen s has certificate

the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica within 2 To the I

> State Registrar

filled in by the

Medical

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number

4,50-236 Clarksville, MD 21029

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nduli Fembera 6030

31. Date filed (Month, Day, Year) APR 2 9 2009

investigation

6 Could not be determined

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Kenneth R. Mills, Sr. ,2009 4:35A April 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1√2 M 2 □ F 90 Yrs Director 212-07-6970 January 6,1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛛 No Middle River 28a-f Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21220 705 Compass Rd. #214 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14 Bace - American Indian 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1941-1945 Specify Ω. 3 X Widowed 4 ☐ Divorced Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", any injury or other traumatic event, I'm Medical Exa Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Pipe Fitter 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Stewart Samue1 Mills ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Md. 21128 9511 Kingcraft Terr. Apt.D Son Kenneth Mills, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14-28-2009 Baltimore City, Md. Gardens of Faith 21. Signature of Furjeral Service Licent 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Parif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs [Lisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the buriaf-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Physician: The certificate Vital 2 X No 1 ☐ Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) HOSPICE 1∐Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No by the after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in within 24 hours Certifier | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only | Check Medical 29a. Certifier completely 29b. Signature and title of dertifier 29d. Date signed Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, State APR 29 Registrar

2009

KENNETH MILLS

		For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of <i>rtificate of</i>			giene , Reg. No. (	2009	1372	
Physicia		1. Decedent's Name (First, Middle, L		HWSKI			2. Date of De Month	ath Day	Year <b>"200"</b>	3. Time of Death	
/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Dea		Ť	ounty of Death	122	
Funeral Director				(In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir	th y, Year) 1965	Cour	place (State or Foreigntry) Tyland	
with the Maryland a or 28a-f show Le rotified at	Director	10a. State 10b. County  Md.  10e. Street and Number		10c. City, Town or Lo	Baltin	more			10d. Inside City 1X Yes 2		
th with 1 23a or		6823 Conley St	reet		10f. Zip Code 21224			10g. Citize	n of What Cour USA	ntry?	
72 hours after death with the Maryland natural", or items 23a or 28a-f show dicel Examiner must be notified at	by Funeral	11. Marital Status  1   Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ሺ No		(Specify Yes or No erto Rican, etc.)		. Race - Americ Black, White, o pecify:		
ithin 72 hours ne. han "natural", e Medical Ere	Completed	15. Decedent's Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	(Give	dent's Usual Occu kind of work done DO NOT use retire	e during most of w ed)	orking	16b. Kind	of Business/Ind	dustry	
ages 1 and 2 should be filed within 72 hours aft and 6 Health and Mental Hygiene. It: If Item 271s marked other than "natural", or y or other traumatic event, Iro Modical Exami	To Be Col	12 17. Father's Name (First, Middle, Las Eugene M. Muraw		Puro	chasing <i>F</i>	18. Mother's Na	ame (First, Middle,	Maiden Su	,	p	
and 2 shoul ealth and M 27 is mari	ř.	19a. Informant's Name/Relationship Karen Maley				t and Number or I	Rural Route Number Balto. Md	er, City or T	own, State, Zip	Code)	
permit. Pages 1 ar Department of Hea Important: If Item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Disponentery, cree Bayview	osition (Name of matory or other pla		Date 28-2009	Balt		ity, Md.	
permit Depar Impor any in		21. Signature of Funeral Service Lice	RineRe	22	2. Name and Addr		Schimune L. Nottin			me 236	
Physician / /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death							
	dical Examiner	Sequentially list conditions, if any, reading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):  consequence of):  consequence of):	M Her	псияна	ne			18 Herns	
that the death certificated by the attending pto detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at t 9  Unknown	Fetal death 3	☐ Ectopic pregnan	су		230	d. Date of delive	ery Day <b>Y</b> ear	
w requires that s been signed to should be deta	ρ	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause gi	ven in Part I.			contribute to th	ne cause of death? ably 4 Unknov	
Physician: The law ra this certificate has be al director, page 2 sh	Completed						24a. Was autop perfor 1 □Yes	sy med?	24b. Were autop prior to cor death? 1 ☐ Yes	psy findings availab npletion of cause o 2  No	
Physician: r this certificaral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ☐ ER/Outpatier	ot 3 🗆 DOA Oti	har:	eath <i>(Check only of</i>		704h (2 )		
uttending death. ctor: After y the funer	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not I 4 Homicide determined	28a. Date of Injury (Month, Day,	28b. Time of Injury	f 28c. Inju Wo M 1		28d. Describe h	ow injury o	ccurred	l Route Number,	
To the Hospital or A within 24 hours after To the Funeral Directional Direction of the Funeral D	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the t vestigation, in my	time, date and pla opinion, death occ	ce, and due to the curred at the time,	cause(s) ar date and pla	nd manner as si ace, and due to	tated. the cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier			29c. Licen			29d. Date s	igned (Month, I	Day, Year)	
Stat Registra	e e	30. Name and address of person who are the TAN BETTAN Ecoup4	th (Item 23a) (Type,  O 4 C/C s Signature	Print)	= 5-001 steen 2	Ave Ral	tina	~ MI	2/22		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

wyensaen McLau	1- For State Certificate of Death	Reg. No. 2009 1372							
Physician/	1. Decedent's Name (First, Middle,Last)  Gwyensean McLaurin	2. Date of Death Month Day Year							
ledical Examiner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De	April 20, 2009							
	Johns Hopkins Hospital Baltimore								
Funeral Director	219-83-0102   1X M 2 F   Yrs. 2	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD							
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
8 .	MD N/A Baltimore	1 X Yes 2 No							
the Maryland at or 28a-f show iffed at once.	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?							
th the Maryland  23a or 28a-f sho notified at once.	2724 Ashland Avenue 21205  11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	U S A  (Specify Yes or No- 14. Race - American Indian, Black,							
5-0036 led within 72 hours after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Put								
safter de ral", or niner mu by Fu	3 Widowed 4 Divorced of Section 1 Yes 2 X No specify:	Specify: Black							
hours a natura	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done retired) N/A 16b. Kind of Business/Industry N/A							
36 iin 721 than "i than "i	Elementary/Secondary (0-12) College (1-4 or 5+)  N/A  N/A								
21215-0036 uld be filed within 72 hours at Menal Hygiene. marked other than "natural c event, the Medical Examin for Be Compoleted by	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	ame (First, Middle, Maiden Surname)							
21 be fi rked ent,	0.170.101.101.101.101.101.101.101.101.10	e E. Watson or Rural Route Number, City or Town, State, Zip Code)							
MD 21 d 2 should th and Me n 27 is max aumatic ev	19a. Informant's Name/Relationship (Type, Print)  Shante E. Watson-Mother  2724 Ashland Av								
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State							
MOF Pages ent of int: If	XX Mt Carmel Cemetery	4-29-09 Baltimore, MD							
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	21. Signature of Funeral Service Licensee  22. Name and Address of Facility	March East F/II							
_ =====	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	ac or respiratory arrest, shock, or heart Between Onset and							
Physician lical	failure, List only, one cause on each line								
xaminer	or condition resulting in death)  Due to (or as a consequence of):								
1	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
nsit Examiner	Course. Erner Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):								
uted Ind									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transity of attending the funeral director, page 2 should be detached for use as the burial - transity of a state of the physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transity of the physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician a	X UNPENDED 23a,27, perME, G894,8/18/09 TI/ #1	TT perME,G906,8/27/10,WS							
760, ficate be g physici the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr	23d. Date of delivery							
Box 687/e e death certifics the attending ped for use as the	past 12 months?  4 Pregnant at time of death 5 Other (Specify)								
Bo he deat y the at hed for	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	23e. Did tobacco use contribute to the cause of death?							
P.O. s. that t		1 Yes 2 V No 3 Probably 4 Unknown							
Records, I The law requires ficate has been sig , page 2 should be		24a. Was an 24b. Were autopsy findings available prior to completion of cause of							
ing Physician: The law required Physician: The law required Physician in the law required Physician configuration in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion of Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in the Portion 1980 in th									
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Physici r this c	1 V Yes 2 No Impatient 2 Produpation 5 500	lursing Home 5 Residence 6 Other:  28d. Describe how injury occurred							
n of									
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the star after dath.  The Tal Division of Microsoft of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of the star of	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division o spital or Attending rouns after death ceral Director: After filled in by the fune	4 Homicide determined (Specify)								
Division To the Hospital or Attendam, within 24 hours after death within 170 the Funeral Director: completely filled in by the		e, and due to the cause(s) and manner as stated.  rred at the time, date and place, and due to the cause(s)							
To the trought comp	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)							
	O.C.M.E.	April 20, 2009							
	30. Name and address of person who completed cause of death (litem 23a)	n MD 21201							
	Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year) 32 Registrar's Signature	E, IVID 2 120 1							
Sta Registra	a a anger h	OGME-							

8

		State of Maryland I-For State Registrar	Certificate of			Reg.	No. 20	009 137					
Physicia dical Examir		1. Decedent's Name (First, Middle,Last) Dimitrui	is M	cNeil		2. Date of Death Month D April 20, 200	ay Year 19	3. Time of Death 1550 hrs					
		4a. Facility Name (if not institution, give street and number 4015 Ardley Avenue		4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of De						
Funeral Director		5. Social Security Number 6. Sex 7. Ac 215-15-3409	e (In yrs. last birthday) 21 Yrs	Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(1	1007 For	Birthplace (State or reign MD					
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	ion				10d. Inside City Limits					
Maryland 28a-f show d at once.	į	MD N/A	BALTIMO					1 <b>X Y</b> es 2 No					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number		10f. Zip Code	2	10g.	Citizen of What C	ountry?					
with the s 23a c		4015 Ardley Avenue  11. Marital Status   12. Was Deceden	t Ever in U.S. 13. Wa	2121 as Decedent of Hispa		ecify Yes or No-	USA 14. Race - Ar	nerican Indian, Black,					
death v rr item nust b	Funeral	1 X XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc											
s after ral", o	اھ	3 Widowed 4 Divorced if Yes, Give Year 1 Yes, 2 X No. specify: Specify: B.											
2 hours	leted	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or	during m	nt's Usual Occupation lost of working life. D			6b. Kind of Busine	ss/Industry					
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Examin	Comple	12th N/A		patcher		7	Zellow	Transporati					
Baltimore, MD 21215-000; permit. Pages I and 2 should be filed withi Department of Health and Mental Hygene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	S	17. Father's Name (First, Middle, Last)		18		(First, Middle, Mai	·						
Z1Z1 Z1Z1 Mental be fil marked c event,	o Be	William P. McNe  19a. Informant's Name/Relationship (Type, Print )		g Address (Street a	Sheil		Honey						
and 2 shou tealth and N tem 27 is n traumatic	-1	William McNeil-fathe		(			•	, MD 21239					
Fe, F F and Health Fitem er trau	ı	20a. Method of Disposition	20b. Place of Dispos	sition (Name of ceme	etery,	Date 2	20c. Location - City	or Town, State					
Definition of the permit. Pages I are Department of Hes Important: If ite injury or other tr		1 XXBurial 2 Cremation 3 Removal from St 4 Donation 5 Other Specify:	25/09	Randa	llstown M								
permit. Departn Import	ı	21. Signature of Funeral Service Licensee		Name and Address o	MA	RCH FUI	NERAL H	OME-EAST					
	-	23a. Part I. Enter the disease, or complications that caused						re, MD 2120 Approximate Interval					
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiac arrythmia											
xaminer		or condition resulting in death)  a. Calulate  Due to (or as a const											
	إ	Sequentially list conditions,	cardiomegal	у				_					
	nine	if any, leading to immediate  cause. Linter Underlying Cause (Disease or injury that initiated	equence of):					4					
insit	Examiner	events resulting in death) Last	equence of):										
<b>≺ecords, P.O. Box 68 / 60,</b> The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Medical		line a-b, P	II,27,per	ME, g891	5/5/09	TT						
Box 68760, death certificate be the attending physic d for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the		4-1 death 3	Ectopic pregnar		23d. Date of deli Month	very Day Year					
BOX 68/6 he death certificate the attending phy hed for use as the l	Physician/N	past 12 months?	t time of death	etal death 3 ther (Specify)		icy	Month	Day Teal					
the at	hys	1 Yes 2 No 9 Unknown 9 Unknown											
res that the signed by	by F	Part II. Other significant conditions contributing to dea Obesity	th but not resulting in the	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Volume Unknown					
dS, equire een sig ould be	Completed	33333,				24a. Was an		e autopsy findings available					
KECOLOS, The law requir. ficate has been si, page 2 should t	ğ		<u>-</u> -			autopsy	ed? deat						
	ပ္ပို	25. Was case referred to medical		26.Place o	of Death (Check of	1 Yes 2 only one)	NO I	Yes 2 No					
VICAL hysician: this certi	To B	examiner?  1 Ves 2 No Hospital: 1 Inpati	ent 2 ER/Outpatient	1 3 DOA O	ther Nursing	g Home 5 Re	esidence 6 🗸 C	ther: Scene					
1 OT ling Ph After funeral	٦	27. Manner of Death  1 X Natural  5 Pending  (Month, Day,	ury 28b. Time of Year)			28d. Describe how	w injury occurred	· · ·					
DIVISION tal or Attendi us after death. al Director: A	catic	2 Accident Investigation			s 2 No	006 16 (04-		- Dural Davida Number City					
s after / s after / al Dire	Certification:	Suicide Could not be	njury - At home, farm, stre	et, factory, office bui	laing, etc.	or Town, Star		r Rural Route Number, City					
등 4 등 등													
To the 2 To the 2 Complet	Medical	one) 2 Medical Examiner:On the basis of examiner and manner stated	amination and/or investiga	tion, in my opinion, o	death occurred at	t the time, date an	id place, and due t	to the cause(s)					
F & F &	ž	29b. Signature and title of certifier		29c. License		1		(Month, Day, Year)					
<u> </u>	- 1	urse Halla	_	O.C.M	.É.		April 21, 2009	)					
		to to the total				<u> </u>							
		30. Name and address of person who completed cause of Carol Allan, MD Assistant Medical Exa		Street Raltimos	re MD 2120°								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MIERZESKI Month. 30 **Physician** OUISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heart Homes Assisted Living Anne Arundel 0denton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F April 15,1922 Pennsylvania Director 87 169-14-6888 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 □ Yes 2 No Funeral Director Odenton Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21113 2454 Apple Blossom Lane #204 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Year or Dates: Specify: Completed by White 3 X Widowed 4 ☐ Divorced "natural", d other than "natural event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Housing College (1-4or 5+) Elementary/Secondary (0-12) & Urban Development Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event once: 17. Father's Name (First, Middle, Last) Be Lazevnick Anna Kavaluinas 2 Peter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mierzeski/daughter-in-law 984 Fall Circle Way Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Ceme 5/12/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Sign are of Funeral Service Licenses Annapolis Road Odenton, Maryland 21113 M00957 1411 Monre 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each lin, Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown ed by the detached o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? page certificate 1 ☐ Yes 2 100 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this OPENTUN 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

29b. Signature and title of certifier

HAZZ

29c. License number

EYENSE

21438

TIGHWA

29d. Date signed (Month, Day, Year)

and manner stated

Am

Registrar's Signat

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:13 A. M April 22, 2009 Eva Maurer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Talbot Hospice House 8. Date of Birth (Month, Day, Year) 10/01/1916 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 1 □ M 2 T F 92 Maryland 216 10 9632 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2X No Director Caroline Preston Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene.
Important: If then 27 is marked other than "naviering any injury or other traumating." 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21655 U.S.A. 7772 Shore Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Lacher Eva Pistel မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Richard Maurer / 202 W. Arden Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Baltimore, Maryland Loudon Park Cemetery 04/27/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signat of Fureral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician reast 0 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 2 **1** No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 6 Nother (Specify) A spice House မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. within 24 hours after death. To the Funeral Director: filled in by

3

Registrar

Medical

31. Date filed (Month, Day, Year) 29

(Check only one)

29b. Signature and title of certifier

Frady DO 2. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221

29c. License number

35

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:30 PM 24, 2009 4c. County of Death April /Medical Anthony Novak
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
9. Birthplace (State or Foreign Country) Gilchrist Center for Hospice Care If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1**⊠**M 2□ F Director 06/21/1932 PA 191-24-5415
Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show s 23a or 28a-f show 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21224 6521 Danville Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 7 is marked other than "natural", or items traumatic event, the Wedical ExaminaCV. Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed wiealth and Mental Hygier n 27 is marked other th Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Stella Hrabski Anthony Nowacki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other troone. Mary Stokes-Novak/Wife 6521 Danville Ave Baltimore, MD 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Ø remation 3 ☐ Removal from State Apr 28 4 Donation 5 Dother (Specify) Beltsville, Maryland 2009 Shocapcake Srematery 22. Name and Address of Fillity 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives Cremation and Funeral Alternatives

8717 Green Pastures Drive Baltimore, Management of the shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory arrest, Interval Between Shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final chron. E Physician Severe cars disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Fl Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2⊠No specel 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely

within 2. To the F

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Novak,

6701

32. Registrar's Sign

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

harles &. Balto and 21204

29d. Date signed (Month, Day, Year)

				For State		State of	Marylar		artment of h		and M		201	0.0	1.0	700
				Registrar  1. Decedent's Name	/First Middle	l act)		Ce	rtificate of	Death		2. Date of Dea	Reg. No. /	19	3 Time	of Death
		Physici		HERMAN .		•						Month APRIL		Ye ar		30P M
4	who say	/Medid Examir		4a. Facility Name (If			nber)		4b. City, Town, o	r Location o	of Death	711 112	4c. County of			
	e di	LAGIIII		STELLA MA	ARIS HO	SPICE			TIMON	NIUM			BALT	IMOF	RE	
		Funeral Director		5. Social Security Nu 214-16-59	mber 6		7. Age <i>(In yr</i> s. <b>89</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da Nov. I	9,1919	9. Birthp Cour Maj	olace (Stat ntry) cylan	e or Foreign d
		w w		Usual Residence of I	Decedent 10b. County		10c Cir	ty, Town or Lo	cation					1	Od. Inside	City Limits
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		death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Num 8100 Ross		Plyd Apt	- 308	-	10f, Zip Code	2123	16		10g. Citizen of W	hat Cour	ntry?	
		er death with Items 23a or	neral	11. Marital Status		12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of H			cify Yes or No-	USA 14. Race		can Indian,	
	980	- a =	5	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed For MXYes If Yes, Giv Year or Da			If Yes, specify Cub 1 □ Yes 2 🛣 No	an, Mexican Specify:		Rican, etc.)	Specify:	, White,	etc. nite	
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5	pur	be file Ital Hy Id othe event,	Be	17. Father's Name (F		ast)						Name (First, Middle, Maiden Surname)				
2009	Maryland 21215-0036	hould nd Mer marke matic	은	Michael I		(Time Print)	<del></del>	19h Maili	ng Address (Street			t Emge	er City or Town 5	State Zir	Code)	
20	<b>∑</b>	alth ar 27 Is r trau		Robert M					W. Jarre				-			21084
. 23,		permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any higury or other traumatic event, Ita Modical Exert once.		20a. Method of Dispo	osition Cremation 3	☐ Removal from S	siaie i	Place of Dispo cemetery, crei	esition (Name of matory or other place Cemetery	ce)	Da	±2009	20c. Location - C	City or To	wn, State	
APRIL	Balti	permit. Departm Importa any inju		21. Signature of Fun				2: L	2. Name and Addre Assahn F 401 Bela	ess of Facility Unera	y 1 Hom	ie		•		
•		Physician /Medical Examiner	iner	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)  Sequentially list contraint, resuming the interval of the cause. Enter Underl Cause (Disease or in that initiated events	t failure. List or Final	a. CHRO  Due to (	ach line.	th. Do not enter		ng, such as	cardiac o	respiratory ar	•	j	Approxim Interval E Onset an	nate Between d Death
	O. Box 68760,	e death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 n 1   Yes 2   9   Unknown	pregnant nonths?	d	oirth 2 🗀 Feta nant at time of	ancy	□ Ectopic pregnand □ Other (specify) _	;y			23d. Date Mon		ery Day	Year
NESLINE	σ.	s that th gned by e detacl	by Phy	Part II. Other signific	cant condition	s contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco use contri	bute to t	he cause o	of death?
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-	of	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To	1  Yes 2  N N  27. Manner of Death 1  Natural 2  Accident		28a. Date of	npatient 2 of Injury h, Day, Year)	28b. Time o	f 28c. Inju Wor	ry at k? Yes 2 □ I	2		dence 6X1Othe		_(у) НО	SPICE
	Division	al or Atter s after dea Il Director ed in by the	Sertifica	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t bo	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		2	8f. Location (8 City or Tow	Street and Numbe vn, State)	r or Aura	al Route N	umber,
		ne Hospita n 24 hours ne Funera pletely fille	Medical C	(Check only 2	2 ☐ Medical E:	Physician: To the caminer: On the back	asis of examina									e(s)
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				30. Name and agare	S Of December	SOUNT	e of death (Ita	m 23a) (Time	K/4	717			4/29	120	7	
10	11			JACKIE J	ONES, C	RNP 230			LEY RD.	TIMON	NIUM.	MD 210	093			
10	,	Sta Registi		31. Date filed (Month	PR 29	2009	egistrar's Signa		arked							

**Physician** /Medical Examiner 8:15anz as the signed by the atte Division of Vital Records, certificate has been tenna 0

completely filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After this

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

2

d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner mast be redified at

and Mental Hygiene.

of Health a item 27 is

other traumatic

Department of Important: If its any Injury or o

72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Be Completed by Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 Natural

5 Pending investigation

2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

cause of death (Item 23a) (Type, Print)

State

29a. Certifier

MPFIRE, COLUMBIA, MD 210

Registrar

09-03172

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Michael Parente 1- For State Certificate of Death Reg. No Registrar 2. Oate of Death 1. Oecedent's Name (First, Middle,Last) Physician/ Month Oay April 20, 2009 1500 hrs William M. Parente Medical Examiner 4c. County of Death 4b. City, Town, or Location of Oeath 4a. Facility Name (if not institution, give street and number) **Baltimore County** 903 Dulaney Valley Rd RM 1029 9. Birthplace (State or Foreign Oate of Birth (MM/OO/YYYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** New York Months Days Hours 116-38-0778 07/20/1949 Director 59  $_{1}X_{M}$ 2 Usual Residence of Oecedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State lin. 1 X Yes 2 No Garden City NY Nassau 28a-f show is 23a or 28a-f show e notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 11530 4 First Street 14. Race - American Indian, Black, 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-12. Was Oecedent Ever in U.S. Funera 11. Marital Status or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 X No Yes White Specify: If Yes, Give Year Yes 2 X No specify: Oivorced marked other than "natural", c event, the Medical Examiner Widowed ultimore, MD 21215-0036

nit. Pages 1 and 2 should be filed within 72 hours after
artment of Health and Mental Hygene.
oritant: If item 27 is marked other than "natural".
ry or other trannantic event, the Medical Examine 3 16b. Kind of Business/Industry 16a. Oecedent's Usual Occupation (Give kind of work done 15. Oecedent's Education (Specify only highest grade completed) during most of working life. OO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Legal Services Attorney Compl 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roccolyn Russo William V. Parente Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 9201 Shore Road, Brooklyn, NY 11209 Pat W. Russo, Uncle 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 04/27/2009 West Babylon, NY L.L. Cremation Co. Donation 5 Other Specify 22. Name and Address of Facility J.A. Mazzarella & Son 21. Signature of Funeral Service Licensee T.Harman 2340 Jerusalem Ave., Bellmore, New York 23a. Part I. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Death /Medical a Multiple Sharp Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions Oue to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED e attending physician for use as the burial Box 68760. 23d. Oate of delivery 23c. If yes, outcome of pregnancy Oay Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the red f 23e. Oid tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by i o Yes 2 ✓ No 3 Probably 4 Unknown ۵ Ω Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has 2 sł nerformed? death? 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other; Hospital: 1 examiner? Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Oeath Stabbed and cut self Certification: FOUND: Yes 2 ✔ No Natural d Director: Pending 24 hours after death. Apr 20, 2009 1445 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 903 Dulaney Valley Rd RM 1029, Towson, MD determined (Specify) Hotel/Motel Homicide 29a. Certifier

Medical within 2 To the I

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD.

egistrar's Signatur

and manner_stated

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

111 Penn Street, Baltimore, MD 21201 **OCME** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 21, 2009

State Registra

Catherine Ann Parente

2009	13	7	3	
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	Registrar  1- For State Certificate of Death Reg. No. 2. Date of Death 3. Time of Death								3. Time of Death				
Physician Medical Examine	er	Decedent's Name (First, Middle,La Catherine Ann	Parente						м Ар	onth oril 20, 20	Day 009	Year unty of Dea	1500 hrs
	4	a. Facility Name (if not institution, gi 903 Dulaney Valley Rd R			4	b. City, Tow Towson		ocation of	Deam	Baltimore County			
		5. Social Security Number 6. S		e (In yrs. last birth	day)	If Under 1		If Under	24Hrs. 8.	Date of Birt			irthplace (State or Foreign
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any		Jsual Residence of Decedent  0a. State 10b. County		10c. City, Town o	r Locati	on							10d. Inside City Limits
		NY Nassa	u	Gard	den	City							1 X Yes 2 No
Maryland 28a-f show d at once.	읽	0e. Street and Number				10f. Zip C	ode			10	0g. Citizen o	of What Co	ountry?
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with the Maryland us 23a or 28a-f sho be notified at once.		1. Marital Status	12. Was Decedent			s Decedent es, specify (						Race - Ame White, etc.	erican Indian, Black,
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funder (Service Licensee T. Harman 22. Name and Address of Facility J.A. Mazzarella & Son 2340 Jerusalem Ave., Bellmore, New York										Sons V York	
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/Medical		failure. List only one cause on Immediate Cause (Final disease	a. Asphyxia										Death
kaminer	-	or condition resulting in death)	Due to (or as a cons	equence of):									
	اير	Sequentially list conditions, if any, leading to immediate	bb. Due to (or as a cons	sequence of):			_						
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ox 6	Sicial	1 Yes 2 No 9 V Unkno		t time of death	5 0	ther (Speci	fy)						J.
Box he death of the attent hed for us	Physicia	Part II. Other significant condition	5 OHRHOWH	th but not recultin	a in the	underlying	ause c	iven in Pa	art I.	23e. Did 1	tobacco use	e contribute	e to the cause of death?
that t	ğ	Part II. Other Significant condition	s contributing to dea	ar out not results	9 117 1110	unicon, mg		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1Ye	s 2 🗸 N	lo 3 F	Probably 4 Unknown
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ital ician: s certil	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; A Nursing Home 5 Residence 6 Other: Scene										Other: Scene		
Division of Vital Records, P.O. Box 6 is a lot Attending Physician: The law requires that the death cert rast ler death.  "In Director: After this certificate has been signed by the attenditied in by the funeral director, page 2 should be detached for use.	٤	1 Yes 2 No 27. Manner of Death	28a Date of In	iury 28h	Time of			ry at Work	28</th <th>d. Describe</th> <th>how injury</th> <th>occurred</th> <th></th>	d. Describe	how injury	occurred	
on on on on on on on on on on on on on o	ioi	1 Natural 5 Pending			JND: 5 hrs		1	Yes 2 🗸	No Su	ubject as	saulted		
ision  Attend  er death.  rector:	icat	2 Accident Investig	28e Place of	Injury - At home, f		eet, factory,	office b	ouilding, e	tc. 28			Number or	r Rural Route Number, City
Divisital or A	Certification:	3 Suicide 6 Could r  4 ✔ Homicide		otel/Motel					90	or Town, 3 Dulaney	Valley Ro	I RM 102	9, Towson, MD
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attenti completely filled in by the funeral director, page 2 should be detached for use.	Medical C		sician: To the best of ner:On the basis of ex	amination and/or	ath occi	urred at the ation, in my	time, di opinior	ate and pl	ace, and du	ie to the cau ne time, date	use(s) and r e and place	nanner as , and due t	stated. to the cause(s)
M 5 m 5 m	Mec	29b. Signature and title of certifier	and manner state	1				se number					(Month, Day, Year)
		Jull /	1	No			o.c.	M.E.			April 2	21, 2009	)
		30. Name and address of person w	no completed cause of	death (Item 23a)				•			1		
		Russell Alexander MD.	Assistant Med		11	1 Penn S	treet	, Baltim	ore, MD	21201			
	ate	31. Date filed (Month, Day, Year)	2009 32. R gist	rar's Signature	1	arke	9					OCME	
Regist	E	APRZS	LUUJ LAN	March Tol.	63								

State of Maryland / Department of Health and Mental Hygiene Stephanie Parente 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 20, 2009 1500 hrs Medical Examiner Stephanie Ann Parente c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 903 Dulaney Valley Rd RM 1029 Towson 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Min New York 08/03/1989 Director 19 077-76-9845  $_{2}X$ М Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 1 X Yes 2 No Garden City 28a-f show NY Nassau hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code United States 11530 4 First Street 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?X White, etc. 1 X Never Married 2 Married Yes White Yes 2 X No specify: Yes. Give Yea Specify: Divorced Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 721 If item 27 is marked other than Dependent Not Self Supporting Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Mazzarella William M. Parente Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 77 Park Hill Ave., Massapequa, NY 11758 Joseph A. Mazzarella, Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/28/2009 Pinelawn, New York St. Charles Cemetery tment c Donation 5 _ Other Specify or 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility J.A. Mazzarella & Son T. Harman 2340 Jerusalem Ave., Bellmore, New York 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial requires that the death certificate be Division of Vital Records. P.O. Box 68760. IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Yes 2 V No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of The law this certificate has performed? death? 2 Νo 1 🗸 Yes ✓ Yes 2 Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one 25. Was case referred to medical Be Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject assaulted FOUND: Natural Yes 2 V No Director: Pending Apr 20, 2009 1445 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 903 Dulaney Valley Rd RM 1029, Towson, MD determined To the Funeral 4 V Homicide (Specify) Hotel/Motel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 21, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD Assistant Medical Examiner State Registrar OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of	Death		Reg. N	No. 20	09 1373	
Physicia Medical Exami	ın/ ner	Decedent's Name (First, Middle,Last)     Betty Ann Parente			A	Date of Death Month Da April 20, 2009	9	3. Time of Death 1500 hrs	
		4a. Facility Name (if not institution, give street and number) 903 Dulaney Valley Rd RM 1029	4	b. City, Town, or Loca Towson			4c. County of Dea Baltimore Co	ounty	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 133–42–8631 1_M 2XF	(In yrs. last birthday) 58 Yrs.	If Under 1 Year If Months Days F	3. Date of Birth (N	of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country).  New York			
nnd Show any <u>ree,</u>	2	Usual Residence of Decedent  10a. State	Oc. City, Town or Locati Garden Ci					10d. Inside City Limits 1 X Yes 2 No	
with the Maryland ns 23a or 28a-f show be notified at once,	Director	10e. Street and Number 4 First Street		10f. Zip Code 11530			nited St	-	
after death ral", or iter	by Fune	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X _{No} If Yo	S Decedent of Hispanic es, specify Cuban, Me:  Yes 2 No specify Susual Occupation (i	ecify:	can, etc.)	White, etc	hite	
5-0036 led within 72 hours Hygiene. other than "natur	Completed	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  College (1-4 or 5-1)	during mo	ost of working life. DO nemaker			Own Hom	•	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Charles Mazzarella		Ca	Nother's Name (Francisco)	Nicolet	ta		
MD 21 d 2 should Ith and Me n 27 is ma tumatic ev	2	19a. Informant's Name/Relationship (Type, Print)  Joseph A. Mazzarella, Cous	in 77 Par	Address (Street and	enue, Ma	ssapequ	a, NY 11	758	
re tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	st. Char	les Cemetei	ry 04/28	3/2009		, New York	
Baltimo permit. Page Department o Important: injury or oth	Ì	21. Standard of Juneral Service Licensee T. Har	23	ame and Address of F 340 Jerusa	lem Ave.	, Bellm	ore, New	ons York	
Physician /Medical xaminer		Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	ne death. Do not enter th	ne mode of dying, such	h as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death	
	Ţ	or condition resulting in death)  Due to (or as a consection of the conditions, if any, leading to immediate to consect of the conditions, if any, leading to immediate to consect of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the condit							
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at ti	2 Fe	tal death 3 E	Ectopic pregnanc	у	23d. Date of delive Month	very Day Year	
, P.O. Be fres that the de signed by the	ò	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given	n in Part I.			e to the cause of death?  Probably 4 Unknown	
Division of Vital Records, P.O. Box 68' the llospital or Attending Physician: The law requires that the death certiff him 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending optiety filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was an autopsy performe	prior ed? death		
Vital Regardicate The his certificate director, page	BeC	25. Was case referred to medical examiner?			Death (Check on	ly one)			
Vit	10.	1 ✓ Yes 2 No Hospital 1 Inpatien			T Training		sidence 6 🗸 O	ther: Scene	
tion of V trending Phydeath. Stor: After tl	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  1 Accident 128a. Date of Injur  FOUND: Day, Ye Apr 20, 2009	FOUND: 1445 hrs	1 Yes	2 ✓ No Si	8d. Describe how ubject assau	lted	44.7	
Division spital or Attendii hours after death. meral Director: A	28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  903								
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examiner and manner stated.	knowledge, death occur ination and/or investiga	tion, in my opinion, dea	ath occurred at t	he time, date and	d place, and due to	o the cause(s)	
	Σ	29b. Signature and title of certifier	m)	29c. License nu O.C.M.E			9d. Date signed (		
		30. Name and address of person who completed cause of de Russell Alexander MD. Assistant Medica	al Examiner 111	Penn Street, Ba	altimore, MD	21201			
St Regist	ate trar	31. Date filed (Mark 29) 2009 33 Registrar	s Signatur	Kal		OCIMI	-		
			-			001411	<b>L</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #21 per FD g890 4/29/09 TT State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 9:17 **Physician** Jeanette M. Royston 4/27/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Broadmead Health Care Center Cockeysville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F 220-18-9996 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28e-f show the Medical Examiner rount by notified at MD Baltimore Cockeysville 1 ☐ Yes 2 🗙 No Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 U.S.A. 13801 York Rd death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Co. other than Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Public Schools other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit then of Health and Mental Heart: If Item 27 is marked ott jury or other treumatic even William Fredrk. Milholland Eunice A. Moody 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Sparks Farm Rd, Sparks, MD 21152 Chris Royston/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department in importent; if any injury or once. 4/29/2009 Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A 21. Signature of Funeral Service Licensee 0717 Creen Pastures Dr, Towson, MD, 21286 Lynda Sue Ritter, M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sayuan ally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam that initiated events resulting in death) Last and Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year director, page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by the Hospitel or Attending Physicien: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2 (Z) No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Loursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 27. Mann-y of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier mpletely (Check only one) and manner stated. 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier 29c_License number Name and address of person who completed cause of deat (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 29 2009

, Jeannette

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 24 Robinson 2009 **Antoinette** /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🕱 F 04 25 52 MD Director 56 212-60-4082 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be rediffed at Baltimore MD 1 Des 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3504 Oakmont Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nursing Aide llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Naomi Gibbs Walter Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 2918 North Edgecombe Circle Violet Robinson-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc 4/29/09 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mu March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. mmeriate Cause (Final ase or condition resulting in death) **Physician** Atrasanca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760; Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Tarkney 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of H	

		_	For State Registrar		partment of Health and M Certificate of Death	ental Hygien Reg. N		
	Dhuaisi		1. Decedent's Name (First, Middle, Las	st)		2. Date of Death	ay Year	me of Death
	Physici /Medic	al	Eugene Rho		4b. City, Town, or Location of Death	Month 2	c. County of Death	1:20AM
	Examin	er	4a. Facility Name (If not institution, give Namor Care —	Roland Park	Politiman	e)	NIA	
	Funeral Director		5. Social Security Number 4.5 4 • 9952		ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (S Country)	itate or Foreign JC
	Maryland f show	or	Usual Residence of Decedent  10a. State  MD  Balti	More 10c. City, Town o	r Location		10d. Insi	ide City Limits
	h with the 3a or 28a- st be notif	Funeral Director	10e. Street and Number	ing Road	10f. Zip Code 21 244	10g. C	Citizen of What Country?	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show minportant: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, I've Medical Exacilinat matter multified at Once.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ocity Yes or No- Rican, etc.)	14. Race - American Indi Black, White, etc. Specify: Ouca	
215-0036	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ducation 16a. De de completed) (G	ecedent's Usual Occupation live kind of work done during most of worki		Kind of Business/Industry	
2121	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinist	S	010 Cup Cor	npany
	ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last) ROSCOL RNDOL		18. Mother's Name	(First, Middle, Maide	en Sumame)	
Maryland	should and Men is marke	²	19a. Informant's Name/Relationship (		ailing Address (Street and Number or Rura	I Route Number, City	y or Town, State, Zip Code)	
	1 and 2 Health a am 27 is		Mary Ellen Tay	10000	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		Location - City or Town, St	
nore	Pages nent of H		20a. Method of Disposition  1 ☐ Burial 2 ★ remation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	isposition (Name of crematory or other place)		altimore,	
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licer		22. Name and Address of acility Question Research	ish C. K	eene Funera Lulstown, MD	isva
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	Appro Interv	oximate ral Between t and Death			
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metaslatu	Prostate Conc	4		
В	Examiner			Due to (or as a consequence of)	on accident mi	th left	12mly	
	ad sit	iner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)	1			
	execute n and al-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequence of)	Heart tarking			
68760,	ficate be executed physician and s the burial-transit	edical		a Coronary	Astery Disease			
	certifica ding ph		IF FEMALE:	23c. If yes, outcome of pregnancy	***************************************		23d. Date of delivery	
.O. Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day	Year
4	w requires that s been signed b should be deta	by	Part II. Other significant conditions of	contributing to death but not resulting in the	ne underlying cause given in Part I.		o use contribute to the cause 2 No 3 Probably	
Records,	8 S C	Completed				24a. Was an autopsy performed	24b. Were autopsy fin prior to completic death?	idings available on of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		h (Check only one)		
	Physical direction	1: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c. Injury at	me 5 Residence 28d. Describe how in	6 Other (Specify)	
sion	Attanding F r death. ector: After by the funera	atlo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigatio	n	M 1 ☐ Yes 2 ☐ No			
Division	el or Atta s after de al Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Rout ate)	e Number,
6	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (	29a. Certifier 1—Certifying Pt (Check only one) 1—Medical Example 1	nysician: To the best of my knowledge, on the basis of examination and/on and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the ca	ause(s)
	To tha within 2 To the comple	Ň	29b. Signature and title of certifier	m	D 31 4 4 4	29d.	Date signed (Month, Day, )  Y 2 7 0 5	(ear)
			30. Name and address of person who	completed cause of death (Item 23a) (Ty	(pe. Print) ENTAW ST Frute	308 13AL	TIMBIZE MI	) 2120,
	Sta Regist		31. Date filed (Month, Day, Year)	320 Registrar's Signature —				
	negist	raī	APR 2 9 20	19 Chiana B. A				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2000 30 AM Physician lorence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** N/A The Johns Hopkins Hospital Date of Birth (Month, Day, Year) 06/02/1924 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Min 1 M 2 X F 84 Vrs Pennsylvania 195 12 8622 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2X No Director Baltimore must be notified Maryland Anne Arundel 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö U.S.A. 310 - 6th Avenue 21225 23a Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 XMarried ö 1 Yes 2X No Specify þ Specify: White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 is marked other than traumatic event, the Me College (1-4 or 5+) 10th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Frank Bolesta Mary Majewski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Cooperfield Court Phoenix, Maryland 21131 Richard Rudy / Son of Health 27 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Lakeview Cemetery 04/24/2009 Sykesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Ligensee namucally 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** muncandia /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No 2 🗌 No 1 Yes certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 $\square$ Nursing Home ၉ 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 🔲 Natural 5 Pending investigation Subject fell 4/18/09 UNKNOWN 1 🗌 Yes 2 X No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined Glen Buthie, MD 4 Homicide building, etc. (Specify) Hospital

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760," in 24 hours after death.

The Funeral Director; After this inpletely filled in by the funeral. within 2 To the F the

the Maryland

with 1

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Certification: Glen Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) RES-DOD 41201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Jose Luis Lopez

600 North Wolfe St, Baltimore, MD, 21287

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Year 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10.00AM Sandra Sonitzer 4pni 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard Abundant Life Assisted Living Home 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 70 008-30-0797 /29/1938 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exantment naist be recified at angle. 10a State 10h. County Director MD Howard Ellicott City 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9966 Oaklea Court 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. 2 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vickie Quickley/ Friend 9966 Oaklea Court, Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4/28/2009 4 Nonation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Line see 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ta tale disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Lell 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi

within 2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ramesh

32. Registrar's Signature

109

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapath

ORIGINAL

29c. License number D30641 29d. Date signed (Month, Day, Year)

BackRiver Neck Road Baltinger Mayley 2122

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g890,04/29/09dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Willard 1613 Speace 4 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner University of Maryland Medical Center Balti more Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 □ F DE 215-34-1501 31 1937 Director Jan. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Muchael Examiner must be retified at once. 1 ☐ Yes 2 ☐ No Director Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 12248 Pointer Hill Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ X Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 □ No ģ Specify white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) automotive care car wash owner & operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Kay Coulson Alonzo Leach Speace ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12248 Pointer Hill Ct., Ellicott City, MD 21042 Sandra King Speace (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 4-20-09 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Parge Haight sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi **Physician** -System Organ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Shock Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Aspiration pneumonia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral Direct filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0068103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villereal, MI S. Greene St Baltimore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2004 **Physician** ULLIVAW PATRICK 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE ler 1 Year | If Under 24 Hrs. CENTER MEDICAL UNIVERSITY OF MARYLAND 8. Date of Birth April 0, Year 950 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) Couptry 5. Social Security Number **Funeral** 1**∑** M 2□ F 59 220-48-8400 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No the Medical Examiner must be notified at Sykesville Carroll Director 10g. Citizen of What Country? 10e. Street and Number USA 21784 604 Sherry Drive 14. Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates: 1970-74 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, train along. White 1 Never Married 2X Married 1 ☐Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) 12 College (1-4or 5+) Claims Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Enid Sullivan Be Edward Sullivan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 Sherry Drive Sykesville, MD 21784 Mrs. Frances Sullivan (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition All County Cremation 4/30/2009 Sykesville, MD 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAICHT FUNERAL HOME & CHAPEL, 21. Signature of Funeral Service Licensee But C Harst MODGY PO Box 195 Sykesville, MD 23

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MOO764 PO Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final METATATIC **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical INFHACTION Examiner MYO CARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed PNEUMONIA and Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 by Physician/Medical 23d. Date of delivery IF FEMALE: yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death Year 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should be RENAL INSUFFICIENCY Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1/No 2 No 1 □ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient ပ္ 28d. Describe how injury occurred this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Medical Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 □ No 1 🗆 Yes investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

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			For State	State of Ma	ryland		rtment of F tificate of I		nd Men		ene g. №. 2 N	00	12	71.5
			Registrar  1. Decedent's Name (First, Middle, La	est)		001	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ate of Death	40	UJ	3. Time	of Death
	Physicia /Medic		Dolores Joseph	ine Stadle	r				Api	Month 24	, 2009	Year	10:40	A. M
4. 4	Examin		4a. Facility Name (If not institution, gire				4b. City, Town, or		Death		4c. County			
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ı	Funeral Director		5. Social Security Number 218–26–0499	Sex 7. Age 1 □ M 2 1 F	79	Yrs.	Months Days		Min. M.	oate of Birth Month, Day Arch I	9,1930	Ma1	place (State ntry) yland	or Foreign
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. City. T	Town or Lo	cation						10d. Inside	City Limits
	Maryla	p		Lto.			tingham						1 □ Ye	s 2 No
	r 28a-	irec	10e. Street and Number	LLU.	-	1100	10f. Zip Code			10	g. Citizen of V	What Cou	ntry?	
	th with	a D	9001 Perryvale	Road			21:	236			1	USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expressor resist to multilised at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1	ever in U.S.		Vas Decedent of H fYes, specify Cuba □Yes 2【No	lispanic Origin an, Mexican, P <i>Sp</i> ec <i>ify</i> :	n? (Specify Puerto Rical	Yes or No- n, etc.)	14. Rac Blac Specify	k, White,	can Indian, etc. nite	-
5-0	72 ho natur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usual Occup	during most of	f working	1	6b. Kind of B	usiness/Ir	dustry	
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ary	shou and M s mar tumat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	g Address (Street	and Number o	or Rural Ro	ute Number,	City or Town,	State, Zi	p Code)	
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Baltimore, Maryland	ges 1 t of Hi if Iter or oth		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	e of Dispo netery, cren	sition (Name of natory or other plac	ce)	Date	2	0c. Location	City or T	own, State	
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Bal	permi Depar Impor any ir		21. Signature of Funeral Service Lice	nsee		22	. Name and Addre	-			Funera			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Swanson /Medical 4a. Facility Name (If not in ditution, give street and number) 4c. County of Death Examiner Kandallstaux Baltimare Hospice Seasons If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2 M 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 by Funeral death . Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Modral Exercities any Injury or other traumatic event, the Modral Exercities any Injury or other traumatic event, the Modral Exercities. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Octavia Brown Walter Olivis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Jason Green Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) stroke **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine pital or Attending Physician: The law requires that the death certificate be executed burs after death. eracle servificate has been signed by the attending physician and eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) of hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | ■ No Medical Certification: To 27. Manner of Death

1 ☐ Natural

2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C TEXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

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31. Date filed (Month

Miller

Smile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarus

32. Registrar's Signature

25

09-03197 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Melody Lea Smith 1- For State Certificate of Death Reg. No Registrar 2. Date of Death ent's Name (First, Middle,Last) Physician/ Month Day April 21, 2009 1330 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 723 Yale Avenue If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Min 1954 Director 011 Country) M Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Yes 2 No or items 23a or 28a-f show must be notified at once more Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Numbe 21229 USA venue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married Armed Forces? 2 Yes Yes, Give Yea Yes 2 No specify: Divorced Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than "numatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 nuestigator 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Sur Be 19b. Mailing Address (Street and Number or Rural Route Number City o 19a. Informant's Name/Relationship (Type, Print) tment of Health and M rtant: If item 27 is ma y or other traumatic e Nhitmore 20b. Place of Disposition (Name of cometery 2 Cremation crematory or other place) 3 Removal from State tment c Other Specify. Donation 5 ne 21 23a. Part I. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval Physician Between Onset and one cause on each line failure. List only /Medical Death a. Asphyxia and blunt force trauma Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death cer ificate be executed Physician/Medical e attending physician ar for use as the burial - t UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte detached for t 1 Yes 2 No 9 ✔ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b þ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, page 2 should 24b. Were autopsy findings available been 24a. Was an prior to completion of cause of autopsy has death? performed? Yes 2 1 🗸 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medica To the Hospital or Attending Physician: Be examiner? Hospital: 1 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this ို 1 ✓ Yes No 28a. Date of Injury After the 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of tniury Certification: Subject assaulted Apr 21, 2009 1331 hrs 1 Natural Yes 2 V No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 723 Yale Avenue, Baltimore, MD determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 22, 2009 O.C.M.E who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 Month **Physician**  $A^{\mathsf{M}}$ Jonita C. Sears April 26, 2:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 15632 Haddonfield Way Montgomery Darnestown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖾 F 316-38-6323 69 Oct. 6, 1939 Indiana Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show : if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Movical Examinating matst be notified at 1 Yes 2K No Directo Maryland Montgomery Darnestown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 United States 15632 Haddonfield Way Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ,or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify <u>ک</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental H ant: If item 27 Is marked oth Be Bernard C. DeVore Henrietta Morse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) G. Michael Sears/Husband 15632 Haddonfield Way, Darnestown, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 29, Department of Important: If any Injury or Montgomery Crematorium, Inc. Bethesda, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc M01548 300 W. Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 23 years **Physician** Melanoma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ing physician and as the burial-tran Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be irector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

s after death.

I Director: After this certifica
ed in by the funeral director, p Certification: To 3 Suicide 4 Homicide filled 24 hours a 29a. Certifier Medical within 24 hoi To the Fune completely f

1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi-29c. License number ſρ April 27, 2009 D38409

30. Name and address of person who ompleted) ause of death (Item 23a) (Type, Print)

William Sharfman, M.D. 10753 Falls Road, # 415, Lutherville, Maryland 21093

31. Date filed (Month, Day, Year) State

APR 29

determined



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For state Amend #8 per FH g891 5/7/09 Tertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:17 Wesley Solace 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ino If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**№** M 2□F Min. a 216-54-573 a Usual Residence of Decedent Director 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MO 10e. Street and Number 10g. Citizen of What Country? 10f Zin Cod Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11 Marital Status filed within 72 hours after Yes 2 No Yes, Give Year or Dates: 1X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hyglene. Elementary/Şecondary (0-12) College (1-4or 5+) OVP 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type Print) (Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If It any injury or o Wings Mills, Md 21. Signature of Funeral Service License 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Metabolic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a sone equal isa of) Examine the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as attending nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Por Day in the past 12 months? Month Year signed by the at d be detached fo 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1∐ Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2⊋No 1 TYes 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

32. Registrar's Signature

BUS

31. Date filed (Month, Day, APR 29

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^{Year)} 2009

			For State Registrar		State	of Mai	ryland		artmen <i>rtificate</i>				1ental Hy	/gien Reg. N	711	09	13750
	Physicia	an	1. Decedent's Name										2. Date of De Month	eath D	ay	Year <b>2009</b>	3. Time of Death
	/Medic Examin		Deborah  4a. Facility Name (/		rimmins	umber)			4h. City.	Town. or	r Location	of Death	MANCIL		c. County		8;0071,
	Examin	ei	Balt. Wasl			,	ter		Gler							Arund	el
	Funeral		5. Social Security N	-	6. Sex		(In yrs. la	ast birthday)	If Under Months		If Under	r 24 Hrs. Min.	8. Date of Bi (Month, D	irth av, Year	-)	9. Birthpl	ace (State or Foreign
-	Director		217-76-4		1 □ M 2 <b>X</b> F		49	Yrs.	Wieriald	Dayo	110010		5/12/1	L959			/land
	and w		Usual Residence of 10a. State	Decedent 10b. County			10c. City	, Town or Lo	cation							10	Od. Inside City Limits
	Maryl f sho	ţ	MD				Curt	is Ba	У								1 ¥Yes 2 □ No
	r 28a	Director	10e. Street and Nur	l mber					10f. Zip	Code				10g. C	itizen of V	Nhat Count	try?
2	h with	a D	401 Grac	e Court	t				212	26				U.	.S.A.		
>	deat	Funeral	11. Marital Status		12. Was Dec	cedent Ev	er in U.S	3. 13.	Nas Deced	ent of Hi	ispanic O	rigin? (Sp	ecify Yes or N Rican, etc.)	0-		e - America ck, White, e	
MAN N3	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show hy Wolfoal Ever, it was the matthed at	by Fu	1 Never Marri		ed 1 🗍 Yes If Yes, G	2 ☑ No live	)		I∐Yes 2		Specify					w. Whit	
28	hours tural	d be	3 Widowed	4 ☐ Divorced	Year or I	Dates:	-	16a. Dece	lont'e Heus	I Occurs	etion			16h		usiness/Ind	
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212		mo;	Elementary/Seco 12	indary (0-12)	College	(1-4or 5+)	,	Compu	ter P	rogi	ramme	er		Inf	orma	tion'	Technology
パカル T) 77% Maryland 21215-0036	1 and 2 should be filed within 72 ho Health and Mental Hygiene. em 27 is marked other than "natur ther traumatic event, I'm Wedical	Be	17. Father's Name	(First, Middle, I	Last)						18. Moth	ner's Name	(First, Middle	e, Maide	n Surnan	ne)	
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いたりかんり Baltimore, Mary	0			□ Cremation	3 Removal from	1 State					i	4/20/	2009	Har	0170 K	· Mar	yland
altir _K	permit. Page Department Important: If any Injury o		21. Signature of Fu		A		Alla	tany Gi	. Name an	d Addres	ss of Facil		atomy				
ä	Deg any	0	1 5	0/50	1)			7!	522 C	onne	lley		Ste.P,			-	-
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,0	icate be executed physician and s the burial-transit		resulting in death) I	Last	Due to	o (or as a	consequ	ence of):	-								
8760,	cate b physic the bi	dical			d												
Box 6	Physician: The law requires that the death certificate has been signed by the attending prained incotor, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, or	utcome of	f pregnar								23d. Da	te of delive	rv
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n G	ding 1 h. After funer	tion	27. Manner of Deat Natural	n 5 ☐ Pending investig	g (Mo	e of Injury nth, Day,	Year)	28b. Time of Injury	M 2	8c. Injur Work	yat k? Yes 2.⊑		28d. Describe	now inj	ury occur	rea	
İSİ	Attending r death. ector: After by the funer	fica	2 Accident 3 ☐ Suicide	6 Could r	at he	e of Injur	y - At ho	me, farm, str			165 2		28f. Location	(Street a	and Numb	ber or Rura	l Route Number,
Ö	tal or rs afte al Dire	Certification:	4 Homicide		build	ding, etc.	(Specify	")					City or To	own, Sta	te)		
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Medical	29a. Certifier (Check only one)		<b>g Physicia</b> n: To th E <b>xamin</b> er: On the and ma		examinat										
	To the I within 2 To the I complet	Me	29b. Signature and	title of certifier					290	. Licens	e number			29d. D	ate signe	ed (Month, i	Day, Year)
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	V		30. Name and addr	ress of person	who completed cau	use of dea	ath (Item	23a) (Type,	Print)	AD.	Calan	2	war is	R	1	2 10	1-1
	Sta		31. Date illed (Mon			Degistrar	's Signal	STA	310	,		01	7.77	/ \	ه المتو	<u>~</u> 0	01
	Registr	ar		APR 29	2009	Lun	v,	B. 10	ark	7							

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2009 | 375 |

		- For State Registrar	Certificate of	Death			g. No.				
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) Maurice Jonathan Toom				2. Date of Death Month April 25, 20	Day Year 009	3. Time of Death 2100 hrs			
		<ol> <li>Facility Name (if not institution, give street and number University Hospital</li> </ol>	) 4	b. City, Town, or Baltimore	Location of Death		4c. County of Dea				
Funeral Director		244 25 2455	e (In yrs. last birthday)  17  Yrs.	If Under 1 Year Months Day		_		irthplace (State or Foreign country) Maryland			
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati			<u>.</u>		10d. Inside City Limits			
/land -f show once.	ē	Maryland N/A	Baltim			110	g. Citizen of What Co	1 X Yes 2 No			
the Mary a or 28a	Director	10e. Street and Number 5323 Carriage Court		10f. Zip Code 2122	9		USA				
21215-0036 hould be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show any nic event, the Medical Examiner must be notified at once.	Funeral		? If Y	s Decedent of Hi es, specify Cuba	spanic Origin? ( S n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black, Black			
ours afte atural"	d by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Deceden	t's Usual Occupa	ation (Give kind of e. DO NOT use ret		16b. Kind of Busines				
36 hin 72 hc e. than "ns edical Es	Completed by	Elementary/Secondary (0-12) College (1-4 or 1 0 th grade	Stud	_	e. DO NOT use let		Carmelo Anthony School				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)			18Mathes Nam Marcia	e (First, Middle, N Patte	Maiden Surname)				
MD 2121 dd 2 should be f ulth and Mental m 27 is marked	To Be	John Toomer  19a Informant's Name/Relationship (Type, Print)  Marsha  Marcia Patterson/Moth	Rural Route Num 1rt Bal	Route Number, City or Town, State, Zip Code) Baltimore, Mary Land 21229							
ore, I s I and of Healt If item	7	20a. Method of Disposition  1	20b. Place of Dispos crematory or of New Catl	ition (Name of ce her place) nedral	Cemetery. 5	/2/09 ry		e,Maryland			
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral School Censee	22. N	Name and Addres	stersto	hatman- wn Rd E	-Harris E Baltimore	Tuneral Home ,Md 21215			
Physician /Medical		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death. Do not enter t	he mode of dying	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death			
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	er	Sequentially list conditions, b									
ed sit	Examiner	Courte. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Courte (or as a consequence of):									
760, cate be executed physician and the burial - transit	Medical	UNPENDED T	8,19a &19b,	perFh G8	3 <b>9</b> 1 5/18/	09 TT					
Sox 68760, leath certificate be exe e attending physician of for use as the burial		23b. Was decedent pregnant in the past 12 months?		etal death 3 ther (Specify)	Ectopic pregr	nancy	23d. Date of deli	very Day Year			
O. Box at the death c dby the atten	튄	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause	given in Part I.			to the cause of death?			
S, P.C puires that an signed I	ed by					1 Ye		Probably 4 Unknown autopsy findings available			
Vital Records, hysician: The law require this certificate has been si director, page 2 should b	ompleted					auto perfo		to completion of cause of n?			
Vital Rec ysician: The his certificate	C	25. Was case referred to medical		26.Pla	ce of Death (Chec						
of Vitang Physici	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpa  27. Manner of Death 28a. Date of Ir			Other Nurs		Residence 6 O	ther:			
ision of \Attending Phy r death. ector: After the	ation	1 Natural 5 Pending Apr 25, 200	Yes 2 No	Subject shot							
Division 14 Hospital or Attendi 15 Hours after death 16 Funeral Director: //	Certification:	3 Suicide 6 Could not be determined (Specify) L	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3200 Normount Ave, Baltimore, MD								
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	Medical C	29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of example 2	kamination and/or investiga	urred at the time, ation, in my opini	date and place, a on, death occurred	nd due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)			
To 1 with To 1	Med	and manner state 29b. Signature and title of certifier	d	29c. Lice	nse number	<del></del>	29d. Date signed	(Month, Day, Year)			
		30. Name and address of person who completed cause of	f death (Item 23a)	0.0	D.M.E.		April 26, 2009	,			
		Melissa Brassell, MD Assistant Medic	al Examiner 111		Baltimore, M	D 21201					
Regi		0 0 0000	trar's Signature	Kar							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year 7:45 AM **Physician** April 24, Brenda J. Thompkins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 11/24/1947 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** DC Country) Months 1 □ M 2 M F 61 Director 577-66-6567 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County r than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at 1 ☐ Yes 2 No Director Silver Spring Montgomery MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20910-Funeral 8500 16th St. #323 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government College (1-4or 5+) other than Elementary/Secondary (0-12) Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F is marked Clara Mae Wiggins Pages 1 and 2 should I nent of Health and Men Edward Neuvart Screven ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 8308 McCullough Lane #103 Gaithersburg, MD 20877permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Donnell Thompkins/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 28 Apr 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral-Service Licenses MO0382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ROGRESSIVE DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending philon at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year Month in the past 12 months? 1 □ Yes 2 🕅 No 5 ☐ Other (specify) Ö the 9 Linknown 9 Unknow as been signed by 2 should be detact ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 **X**No 1 □Yes 21 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4  $\square$  Nursing Home 5  $\underline{\square}$  Residence 6  $\underline{\square}$  Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient Certification: To After this 27. Manner of eath
1 Natural
2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending s after death. 1 ☐ Yes 2 □ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H (045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO, 1500 FOREST GUENRO, KISHORE 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 6:30AM **Physician** /Medical or Lacation of Death eyand number) not institution aive str Examiner dalls town If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Months Min Hours Days Ma 1**ఏ**&M 2□ F Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XYes 2 □ No imore. Funeral Director 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, e.c. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes · 2 ☑ No If Yes, Give Year or Dates: Specify 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MShore 18. M 17. Father's Name (First, Middle Be 10 mgs d imon 2 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Son 202 nom as 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F neral Service Licens N. fulton Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Motabolic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alcoholism Sequentially list on altimates if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) cate has been signed by the apage 2 should be detached to 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? r this certificate had director, page 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation reral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DGbDG BVV72N 2735 S

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Smith Avonue Svite 203 BaltmoroMD

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Physician	
/Medical	

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State of	th and N	lental Hygi	ene					
	Ce	Doath	eath Reg. No. 2 0 0 9					
e, Last)							3. Time of I	Death
Joseph	h William Tori	ian		APIZOL	23 a	2009	19:03	PM
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TAL		Balt		2+>	l N	V/A		
6. Sex	7. Age (In yrs. last birthday)			8. Date of Birth	Voarl			r Foreign
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City, Town, or  TAL  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year	State of Maryland / Department o th and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department o the and Maryland / Department	State of Maryland / Department o th and Mental Hygical Certificate of Death Research  State of Maryland / Department o the and Mental Hygical Research  Certificate of Death Research  Joseph William Torian  4b. City, Town, or Location of Death  TAL  Baltimule CITY  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 His. Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month, Day  Month,	State of Maryland / Department o the and Mental Hygiene  Certificate of Death  Reg. No. 2 [ e, Last)  Joseph William Torian  1. Give street and number)  4b. City, Town, or Location of Death  TAL  1. BALT mule CITY  Month, Day Year)  1. Month, Day Year)  Month, Day Year)	State of Maryland / Department o th and Mental Hygiene  Certificate of Death  Reg. No. 2 0 9  e, Last)  Joseph William Torian  4b. City, Town, or Location of Death  Reg. No. 2 0 9  Year  Month, Day Year  Ac. County of Death  N/A  6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.  Note of Maryland / Department o th and Mental Hygiene  Reg. No. 2 0 9  Year  N/A  9. Birthp  County of Death  N/A  6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.	State of Maryland / Department o th and Mental Hygiene  Certificate of Death  Beg. No. 2 9 3  e, Last)  Joseph William Torian  4b. City, Town, or Location of Death  The Baltimal Clty  6. Sex 7. Age (In yrs. last birthday)  Months Pay Hours Min 8. Date of Birth  Months Pay Hours Min 8. Date of Birth Day Year  Months Pay Hours Min 8. Date of Birth Day Year  Months Pay Hours Min 8. Date of Birth Day Year  Country)

**Funeral** Director

Examine

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Examinat must be ratified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, 💪

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month,	n Day	Year	3. Time of	Death
an al	Joseph W	illiam Tor:	ian		APRIL		2009	19:03	PM
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death	1	4c. County	of Death		
	HARSON HOSPITAL		Bala	timore C	2+>	N	/A		
	480 4 00 5	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State o	r Foreign
	231 12 10/5	88 Yrs.			07/17/			inia	
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ncation		·		10	d. Inside Cit	ty Limits
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ect	Maryland Anne Arundel  10e. Street and Number	Baltim	10f. Zip Code		11	Og. Citizen of V	Mhat Count		
To Be Completed by Funeral Director				1005				ı y :	
eral	214 Orchard Avenue  11 Marital Status 12. Was Decedent	Ever in II.9		1225	nasify Van or No	U.S.	• A • ce - America	n Indian	
ä	11. Marital Status 12. Was Decedent Armed Forces? 1 ☑ Never Married 2 ☑ Married 1 ☑ Yes 2 ☑	Vo	Was Decedent of I If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		ck, White, e		
by	3 ☑ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:	WW IT	1 ☐Yes 2 <b>X</b> No	Specify:		Specify	y: Wh:	ita	
ed	15. Decedent's Education	16a. Dece	edent's Usual Occu	pation	11	l 16b. Kind of Bu			
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondary (1-4or secondar	life	e kind of work done DO NOT use retire	during most of wor d)	king				
mo:	12th		ationery	Engineer		0i1 (	Compan	ıy	
3e C	17. Father's Name (First, Middle, Last)			1	ne (First, Middle, M		ne)		
0	John Tori	an		Kat	e Thatch	er			
	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street		ıral Route Number,	City or Town,	State, Zip	Code)	
	William Torian / Son	214	Orchard A	lvenue	Baltimo	ore, Ma	ry1an	d 2122	25
1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other pla	ce)	Date 2	20c. Location -	City or To	vn, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Glen Have			7/2000	Glan Ri	ırnio	Mary	1and
	21. Signature of Funeral Service Licensee	2	2. Name and Addre	ess of Facility Go	once Fune	ral Ser	rvica	РΛ	ranu
	Varage Manamino	uski 1	4001 Ritc	hie Highv	av Balt	imore,	Marv]	and 2	1225
27.55	23 Part1. Enter the disease, or on plications that cause shock, or heart failure. List or yone cause on each li	the death. Do not en	ter the mode of dyi	ng, such as cardiad			2	Approximate Interval Bety	9
	Immediate Cause (Final		Onset and D	Death					
	disease or condition resulting in death)  Due to (or as	a consequence of):	ARCITO	7			- 1	mned	, pro
	(171)	, ,	7 Discus	e				YEAR	5
je	Se uentially list conditions. If any, leading to immediate  Due to (or as	a consequence oi):	, , , , ,						,
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Ě		a consequence of):							
ical	d								
Completed by Physician/Medical Examiner	IE EDMI E								
N/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2  Fetal death 3	□ Ectonic pregnanc	~v			te of delive	•	
sicie			Other (specify)			Mo	onth	Day Y	ear/
μŽ	9 ☐ Unknown								
J Y	Part II. Other significant conditions contributing to death b	0 (	ınderlying cause giv	ven in Part I.	23e. Did tob	acco use cont	tribute to th	e cause of d	eath?
ed	RECENT CEREBROVASULAR A	cident.			1 □ Ye	s 2 No	3 ☐ Proba	ably 4	Inknown
plet	PAROXYSMAR ATRIAL F	IBAILLAT	700		24a. Was ar		Were autop	sy findings a	available
E	HYPERLIPIDEMIA				autopsy perform	ned2	death?	ipietion of ca 2 □ No	1056 01
Be	25. Was case referred to medical			26. Place of Dea	th (Check only one			21,110	
	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing H	ome 5 Reside	nce 6 □Oth	ner (Specify	)	
ü	27. Manner of Death 28a. Date of Inju 1. Natural 5 ☐ Pending (Month, Da	ry 28b. Time o	of 28c. Inju	ry at	28d. Describe ho	w injury occur	red	·	
atic	2 Accident investigation	,,,,,,		Yes 2□No					
ti ii	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, et	ury - At home, farm, st	reet, factory, office		28f. Location (Str	reet and Numb	er or Rura	Route Numi	ber,
27. Manner of Death 1 Natural 2 Accident 3 DOA 28a. Date of Injury 4 Norman Street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. L									
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Σ	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signe	d (Month, L	Day, Year)	
	A Bukovi	te mo	Do	061438	3 1	4PRIL	23 %	2009	
	30. Name and address of person who completed cause of	eath (Item 23a) (Tyne	Print)			<del></del>			
	ANDREW BUKOVITZ MD	3001 Sout	LHAnover	St. BA	Himore 1	MD a	11225		
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ar	APR 29 2009 Lengua	1 19 19 W	M. C.						

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Pri n Black Indelible Ink. Ensure All Copie re Legible.

State of Maryland / Department of Health and Mental Hy 2009 13755 Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day February 5, 2009 Physician/ 0425 hrs Medical Examiner Gerardo Elias Botello Vega 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Montgomery Germantown 270 S. Father Hurley Blvd. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 10/03/1968 Rep of Panama Director 1 X M 2 40 Yrs none Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County any 10a State 1 X Yes 2 No New York s 23a or 28a-f show e notified at once. 28a-f show Brooklyn the Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number Republic of Panama 11203 4519 Clarendon Road Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items must be Armed Forces? Married death Never Married 2 2 X No Yes Specify: White 1 X Yes 2 No specify: Pages I and 2 should-be filed within 72 hours after onen of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", one other traumatic event, the Medical Examiner man or other traumatic event, the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical Examiner man of the Medical 4 X Divorced f Yes. Give Year Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15: Decedent's Education (Specify only highest grade completed) unk during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Entrepeneur 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aida Vega Gerardo Botello Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Significant ٥ Baltimore, MD 2: permit Pages I and 2 should Department of Health and M Important: If item 27 is not injury or other traumatic e-4519 Clarendon Road, New York, NY 11203 Valisneria Rodriquez/ Other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Ardent Cremation Services 04/29/2009 Hanover, Maryland Other | Specify: 22. Name and Address of Facility Ardent Cremation Services Donation 5 21. Signature of Funeral Service Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death Vedica a. Multiple Gunshot Wounds Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine Cause. Et ter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit Physician/Medical AMENDED UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FFMALE: Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth use as t past 12 months? Pregnant at time of death Other (Specify) 5 ned by the atte detached for u 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? certificate has 1 V Yes ✔ Yes 2 No page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Other₄ Residence 6 V Other: Scene Hospital: 1 DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 this ٩ 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death After Subject shot Certification: FOUND: Natural Yes 2 Pending Director: 0405 hrs hours after death. Feb 5, 2009 UNK 28f, Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 270 S. Father Hurley Blvd., Germantown, MD 3 Suicide determined (Specify) Found by side of road 4 V Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 5, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Year **Physician** 10:30 AM 2009 Georgeanna Berthier VanHorne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/28/1945 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 🔽 F 63 Director 214 44 1075 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating that the notified at 1 ☐Yes 2X☐No Director Anne Arundel Linthicum Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 732 Wedeman Avenue 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2**X** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐Yes 2 No Specify: Specify: White <u>2</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 12th Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bentley Bossom Gladys Mae Doggett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra 40 Bremer Drive Glen Burnie, Maryland 21061 John VanHorne Jr. / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/28/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a. Pirt1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FULMINANT LIVER FAILURE 2-3 DAYS /Medical Due to (or as a consequence of): Examiner X-1DAYS ANOXIC ENCEPHALOPATHY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 1-2 DAYS Hospital or Attending Physician: The law requires that the death certificate be execute FAILURE sician and burial-trans ACUTE RENAL Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 1-2-DAYS METABOLIC ACI DOS15 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown reral prector: After this certificate has been signed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>a</u> ALCOHOL ABUSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 No Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1∐ Yes 2∭ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , M.D P22002 APRIL, 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE, BALTIMORE, MD RADHIKA KALISETTI, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

GEORGEANNAC

VANHORNE

			. For Sta	te of Maryland / Dep	artment of Health and	Mental Hygier	1e	10353
			State Registrar	Се	ertificate of Death	Reg. N	10.2009	13/5/
П	Physici	an	1. Decedent's Name (First, Middle, Last)	a in this !		2. Date of Death Month	Day Year	3. Time of Death
-	/Medio Examin		4a. Facility Name (If not institution, give street a	entine	4b. City, Town, or Location of Deat	h 4 2	4c. County of Death	17/3/
N. S.			Northwest Ho.	spital	Randailstown		Baltin	
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	show show	ō	10a. State 10b. County	10c. City, Town or L	cocation			10d. Inside City Limits 1
	r 28a-f	irect	10e. Street and Number	Bait	10f. Zip Code	10g. (	Citizen of What Cou	
	th with	<b>Funeral Director</b>	5524 W. North	Ave.	21207		USA	
	items	nne	Arn	s Decedent Ever in U.S. ned Forces? Yes 2 □ No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Ye's or No- to Rican, etc.)	14. Race - Ameri Black, White,	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Examinant be incitified at	þ	If Ye	es, Give ar or Dates:	1 □Yes 2 No Specify:		Specify: BI	acK
15-0	"natur	letec	15. Decedent's Education (Specify only highest grade comp.	leted) (Give	edent's Usual Occupation e kind of work done during most of wo	rking 16b.	Kind of Business/Ir	ndustry
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pu	tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)	1.		me (First, Middle, Maide	en Surname)	10000
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	and 2 s ealth an n 27 is i		Mrs Clarice F	Sowen 211	ling Address (Street and Number or +-	al Route Number, City	Bulto N	1121207
ore,	es 1 a of Hea of item or othe		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal	20b. Place of Disp	position (Name of ematory or other place)	Date 20c.	Location - City or To	own, State
Baltimore,	Pa ant: ury		4 Donation 5 Dother (Specify)	Garris	son Forest: 3/4	12009 Du	Jings N	IIIS, Ma.
Ba	permit. Departr Importa any inja		21. Signature of Funeral Service Licensee	Run 5	2. Name and Address of Facility 2. Russ	Fungral	Home, P.	A.
			23a. Part 1 Enter the distase, or complications shock, or heart fail re. List only one caus	that caused the death. Do not er	nter the mode of dying, such as cardia	c or respiratory arrest,	5. IVIA. 2	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition resulting in death)	omprention	lung Canco	V		Onset and Death
1	/Medical Examiner		D	ue to (or s a consequence of):	)			
	it od	iner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury	us to (or as a consequence of).				
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89 x	ertifica ling ph e as th	Med	IF FEMALE:					
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P.O.	w requires that the death certific been signed by the attending p should be detached for use as t	Physician/Medical		] Unknown				
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COL	w requ	Completed				24a. Was an		opsy findings available
Re	The law ate has bage 2 s	omo				autopsy performed? 1 □Yes 2 ☑1	prior to co	impletion of cause of
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of	Physic r this c	٦.	11 Yes 2 No Hospital: 27. Manny of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatie		forme 5 Residence		ify)
ion	ath. r: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No	Edd. Deddilbe flow in	ary obcarred	
Division of Vital Records,	or Atte	Certification: To	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street and City or Town, Sta		al Route Number,
Ц	spltal		29a. Certifier Certifying Physician:	To the best of my knowledge, dea	th occurred at the time, date and place	e, and due to the cause	e(s) and manner as	stated.
1	To the Hospital or Attending Physician: The law requires that the death certificawithin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending placemental prector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: Or and	the basis of examination and/or it d manner stated.	nvestigation, in my opinion, death occi	urred at the time, date a	and place, and due t	to the cause(s)
'	To vit	2	29b. Signature and title/of certifier	D	29c. License number 70062650		Date signed (Month,	Day, Year)
			30. Name and address of person who completed	d cause of death (Ite 23a) (Type	, Print)	· ·	11 - 5/00)	
			5201 Bahab 1800	7 Ring Ray	indullston MD	21133.		
	Sta Registra		31. Date filed (Month, Day, Year)  APR 2 9 2009	2. Registrar's Signature	Kad			
			711 11 17 2	///				

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AMEND TTEM#5perFH, G*91.5/8/09.WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Spencer Maurice Vanison, Jr. April 21, 2009 11:20 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) -70-3158 **Funeral** Hours Min Days <u>1</u>, 1 M 2 □ F 56 Yrs 1952 **Director** June Washington D.C. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Exeminar must be notified at ty⊑Yes 2 ☐ No Director Takoma Park Montgomery MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 2 20912 United States 8306 Barron St. #21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 GYes 2 No If Yes, Give Year or Dates: 1972-79 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2X No Black Specify Specify ģ 3 ☐ Widowed 4 X Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Computer Programer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental and Mental Maurice S. Vanison, Sr. Barbara Mary White ၉ traumatic 19a. Informant's Name/Relationship (Type. Print)
Domestic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once. Dawna Phillips / Partner 8306 Barron St. #21, Takoma Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 1 Maryland Veteran's Cem. Crownsville, MD 2009 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services 933 Gist Ave.. Silver Spring. MD Rapp Funeral & Cremation Set 933 Gist Ave. Silver Spring Shock, or heart failure. List only one cause or each line. 20910 Approximate Interval Between Onset and Death Immediate Cause (Final 01 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed ending physician and use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 □ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Manner of Death . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Division 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

APR 2 9 2009

DHMH 17 Rev 1/2001

s of person who completed cause of death (Item 23a) (Type, Print)

7600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last)  Robert Wheat  2. Date of Death Month Day Year April 24, 2009  3. Time of Death 1555 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2747 Washington Blvd.3rd Floor  Baltimore  4c. County of Death
Funeral Director	5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  17. Age (In yrs. last birthday)  18. Date of Birth (MM/DD/YYYY)  9. Birthplace (State or Foreign  Count (Nary) and  Count (Nary) and
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any or traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	State   10b. County   10c. City, Town or Location   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Street and Number   10f. Zip Code   10g. Citizen of What Country   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limits   10d. Inside City Limit
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic	Deborah K. Morgan/sister  485 Bruce Avenue Odenton, MD 21113  20a. Method of Disposition  Burial 2 X Cremation 3 Removal from State  Donation 5 Other Specify:  Ture of uneral Service Licensee  T. Harman  20b. Place of Disposition (Name of cemetery, crematory or other place)  Atlantic Cremator y 04/28/09 Glen Burnie, MD  22. Name and the first state And to my Doard of MD 21061  Control of Disposition (Name of cemetery, crematory or other place)  Atlantic Cremator y 04/28/09 Glen Burnie, MD  22. Name and the first state And to my Doard of MD 21061  Control of Disposition (Name of cemetery, crematory or other place)  Atlantic Cremator y 04/28/09 Glen Burnie, MD 21061  Control of Disposition (Name of cemetery, crematory or other place)  Atlantic Cremator y 04/28/09 Glen Burnie, MD 21061  Control of Disposition (Name of cemetery, crematory or other place)  Atlantic Cremator y 04/28/09 Glen Burnie, MD 21061
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
760, cate be execut physician and the burial - tra	d. UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions  d. MENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown  23d. Date of delivery Month Day Year
P.C es that gened   be deta	1  Yes 2 No 3 Probably 4 ✓ Unknown  24a. Was an autopsy performed? 1 Yes 2 No No 3 Probably 4 ✓ Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No 1 Yes 2 No  25. Was case referred to medical  26. Place of Death (Check only one)
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been st completely filled in by the funeral director, page 2 should the Medical Certification: To Be Completed	examiner? 1
State Registra	30. Name and address of person who completed cluse of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  ORIGINAL

			For State Registrar	State of M	-	partment of learning of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the co			giene Reg. No.2009	13760		
f	Physici		Decedent's Name (First, Middle, L Cherlyn Denice V					2. Date of De Month April	24, 2009	3. Time of Death 2:55 PM M		
ANT Y	/Medio Examin		4a. Facility Name (If not institution, ga Casey House			4b. City, Town, c	r Location of D	Death	4c. County of Deat			
H	Funeral Director		133-52-2801	Sex 7. Ag 1 □ M 2 🗷 F	ge (In yrs. last birthd 50 yrs	Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da 10/31	th 9. Birt Ay, Year) Co 1./1958 NY	hplace (State or Foreign untry)		
	Maryland f show	tor	Usual Residence of Decedent	merv	10c. City, Town or					10d. Inside City Limits 1   Yes 2 □ No		
	with the Na a or 28a-	I Director	10e. Street and Number 15 Orchard Dr.		042 0110	10f. Zip Code 20878	_		10g. Citizen of What Co	•		
36	s after death ", or Items 2:	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Ayes 2 If If Yes, Give Year or Dates:	No	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☒ No		? (Specify Ye's or No ruerto Rican, etc.)		rican Indian, e, etc.		
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, it a Medical Evan inversing to realified at	Completed b	15. Decedent's E (Specify only highest g.	ducation	16a. De (G	ecedent's Usual Occupive kind of work done e. DO NOT use retire	during most of	i working	16b. Kind of Business/ Health Car	Industry			
	To Be Cor	17. Father's Name (First, Middle, Las Lee Artis Hollan	•	2 Nu	rse		Name (First, Middle, eda Willia					
2	es 1 and 2 should bot Health and Ment i item 27 Is marked r other traumatic e		19a. Informant's Name/Relationship Louis L. Wilkins,			-			er, City or Town, State, 2	Zip Code)		
baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.						:	Date May 11 2009	20c. Location - City or Arlington,			
Balt	permit. Departimports any inj		1⊠ Burial 2 □ Cremation 3 □ Removal from State   cemetery, crematory or other place) May 11									
	Physician /Medical Examiner		23a. Part1. Enler the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	rrest,	Approximate Interval Between Onset and Death							
,000	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):  Due to (or as a consequence of):							
.O. Box 687	To the <b>rospital or Attending Frigstoant:</b> The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey .		23d. Date of del Month	ivery Day Year		
ecords, 1	quires ma en signed uld be dei	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause giv	ren in Part I.		obacco use contribute to Yes 2 ☐ No 3 ☐ Pr			
al Reco	cate has be page 2 sho	Completed						24a. Was autop perfo 1 □ Yes	osy prior to death?	atopsy findings available completion of cause of 2 □ No		
VII al	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		tient 3 DOA Oth	or:	Death (Check only o		0.1		
5 6	a rnys er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Man er of Death	28a. Date of Inju	ent 2 ER/Outpa ury 28b. Tim	e of 28c. Injur	4 Li Nursii		dence 6 Other (Spe	city) Hospies 1911		
DIVISION OF	our nospinal or Attending Fritysicans, within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director, I	Certification: To	1 Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not 4  Homicide determined				k? Yes 2∐No	28f. Location (S	Street and Number or Ru wn, State)	ural Route Number,		
1	e nospiral 24 hours a e Funeral D letely filled	Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination and/o	eath occurred at the ti r investigation, in my	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)		
	within Volume comp	Me	29b. Signature and title of certifier  Jocelyne k	ouarcho	u, m)	29c. Licens	e number 63 74		29d. Date signed ( <i>Monta</i>			
_			30. Name and address of person who Jocelyne Kavatcho	eMD M	uncoster	110	Rock	nue Mol		-		
	Sta Registra	te ar	31. Date filed (Month, Day, Year) APR 2 9 2009	32. Registr	ar's Signature	(d)						

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician Month Day Ye ar 9:57 AM M Timothy Michael Watts April 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Months Hours 47 Director 12/31/1961 <u>216-92-2088</u> MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hygiene. The marked other than "natural", or items 23a or 28a-f show the traumatic event, Its Mexice Exc. nitem. In the Lymine 1 and the traumatic event, Its Mexice Exc. nitem. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Sykesville MD Carroll 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 1131 Shortleaf Cir 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 24€No 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) UPS Elementary/Secondary (0-12) College (1-4or 5+) Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathanel Emmitt Watts Nancy Lee Holcombe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah E. Shifflett/Sister 1131 Shortleaf Cir. Sykesville, MD 21784 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 Cremation 3 Removal from State Apr 4 ☐ Donation 5 ☐ Other (Specify) 2009 Beltsville, Maryland Chesapeake Crematory 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives a 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. En ar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AA STA **Physician** erk disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be execute anding physician and use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 □Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death al or Attending P s after death. I Director: After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 □Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Charles St. State Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760~

Récords,

Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 20aperFH, G891, 57, 1709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day
April 23,2009 Marie E. Wingrove 1:35P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Nottingham Balto. 3730 E. Joppa Road 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 21X F Months Days Hours May 7,1930 Maryland 218-26-2724 78 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Balto. Nottingham 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3730 E. Joppa Rd. 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew F. Wolf Elizabeth Buckinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 E. Joppa Rd. Nottingham, Md. 21236 Nicholas R.Wingrove, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-27-2009 Timonium, Md. 4 ☐ Donation 5 ∰ Other (Specify) Emtombmen Dulaney Valley 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery I ☐ Live birth 2 ☐ Fetal death I ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths? 1 □ Yes 2 □ No Dav 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

11 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

o the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. attending physician for use as the buria P.O. 1 ned by the a signed I Division of Vital Records, has , page certificate After this certific funeral director,

and burial-

Physician

Examiner

**Funeral** 

Director

28a-f show

Director Md

Funeral

2

Completed

Be 2

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

death with the Maryland

72 hours after

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumation.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Jospital c. 24 hours after dea. "-eral Director: After וס עני. within 24 hours auc. To the Funeral Direct

> State Registrar

31. Date filed (Month, Day, Year!

29b. Signature and title of certifier



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 APRIL -IAM 4c. County of Deat Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death TIME HALWDED BURNIE PLTIMORE WASHINGTON GLEN 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Min. Months Days Hours 1⊠M 2□ F 217-34-3387 July 10 1936 MD Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City Town or Location Pasadena 1 ☐ Yes 2 No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Winston Road 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Construction 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Walker Juanita Albiker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 109 Winston Road, Pasadena, MD 21122 Glenda Kay Walker (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Libensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or o implication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart illure. List only ne cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) neumonia Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery regnant 3 Ectopic pregnancy onths? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner** 

per nit. Pages 1 and De artment of Healt Important: If Item 27 any Injury or other to

Physician

Examiner

**Funeral** 

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Funeral Director

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Completed

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/Medical

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the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

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IF FI	EMALE:
23b.	Was decedent p
	in the past 12 m

1 ☐ Yes 2 X No 9 Unknows

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? res 2 No

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

28a. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Naturai

2 ☐ Accident

3 Suicide

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cer

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of pegs in who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last, Month **Physician** 00 2009 /Medical Facility Name (topt institution, give street and numb Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Year If Under 24 F 8. Date of Birth (Month, Day, rs last birthday **Funeral** Min. Months Days Hours 1 □ M 2 🔀 F Director Usual Residence of Dece 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2▼No Specify. ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4or 5+) Name (First, Middle, Last) 17. Fath Be aine noma ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Pages 1 and 2 s ment of Health an Health atem 27 ls permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - C 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signalury of Funeral Servi e License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Unknown Immediate Cause (Final **Physician** disease or condition resulting in death) UMOY /Medical Due to (or as a consequence of) UNKHOWN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown funeral director, page 2 should Completed peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: A filled in by the for 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only 29c. License number 29b. Signature and title of certifier 2009 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nazi Union emorkil rars1 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03284 State of Maryland / Department of Health and Mental Hygiene James Wilburn, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0130 hrs James Edward Wilburn, Jr. April 24, 2009 **Medical Examiner** 4b, City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Country) Months Hours Mir Director Virginia 1 X M 2 F 53 11/04/1955 West 212 76 7289 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 1 Yes 2 X No Marvland Anne Arundel Baltimore 23a or 28a-f shornorified at once. the Maryland 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 21225 U.S.A. 9 - 14th Avenue 靣 death with 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status must be Armed Forces 1 Never Married 2 X Married Yes White . Pages 1 and 2 should be filed within 72 hours after (ment of Health and Mental Hygiene.
-tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner m Yes 2 X No specify. Specify: f Yes. Give Yea Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Supervisor Balto, City Garage 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Edward Wilburn, Sr. Carolyn Fuggett Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 111 - 12th Avenue Baltimore, Maryland 21225 James Wilburn, III / 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 crematory or other place) Removal from State Bayview Crematory 04/29/2009 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 amucely Part I. Enter the disease, ocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Contact Gunshot Wound of Chest Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Caus. Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 2 No No ✓ Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital: 1 Other₄ Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ဥ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Apr 24, 2009 Subject shot self 0036 hrs 1 Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 9 14th Avenue, Baltimore, MD (Specify) Single Family 4 Homicide

the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi upletely filled in by the funeral director, Division of Vital To the Funeral Dir within

> Carol Allan, MD 31. Date filed (Month) State

Registrar

Medical

29a. Certifier 1

29b. Signature and title of certifier

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32. Registrar's gignatur

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 24, 2009

4	For State Registrar			repai aire	arit Oi i	neaiii a	and iv	lental Hy	Are Le				
				Certifica				,	Reg. No.	100	12766		
	I. Decedent's Name (First, Middle, L	,						2. Date of De		<del>)                                    </del>	3. Time of Death		
Physician /Medical	Norma M. Atwel	. Atwell								2009	10:45 P M		
	a. Facility Name (If not institution, g 20 Boxwood Road					or Location of Annap	olis	s Anne Aruno			undel		
Director	. Social Security Number 6. 216–32–1802  Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. last birt	rs. If Uni	der 1 Year ns Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 4,	th ay, Yea <i>r)</i> 1937	9. Birthr Cour <b>Ma</b> 1	place (State or Foreign ntry) ryland		
	0a. State 10b. County Maryland Anne Ar	rundel	10c. City, Town	or Location	Anı	napoli	s			1	10d. Inside City Limits 1 X Yes 2 □ No		
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Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene.  Important: I file m 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Hedical Evacinic matter notified at once.  To Be Completed by Funeral Director	Marital Status     □ Never Married 2	12. Was Decedent Armed Forces? 1 □ Yes 2 XX If Yes, Give Year or Dates:			cedent of hoecify Cub		gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	14. F E Spe	Race - Americ Black, White,			
21215-00 ed within 72 hou yegiene. ner the meurs it, the Medical E	15. Decedent's Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	16a.	Decedent's U (Give kind of I life. DO NOT	_		of workir	ng		Business/Inc			
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laryla should and Mer is marke aumatic	9a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Addre	ss (Street	and Numbe	r or Rura	Known)	er, City or Tov	vn, State, Zip	Code)		
re, M	Allen Atwell/nephew P.O. Box 87 S. Freeport, Maine 04078  20a. Method of Disposition Date 20c. Location - City or Town, State												
Baltimore, Maryland 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hyglens Inportant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Hedical Evac.  To Be Completed by F													
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Examiner													
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30.	Name and address of person who 139 of 5 of our Date filed (Month, Day, Year)  APR 14 2	completed cause of de	eath (Item 23a) (T	ype, Print)	4.5.	64 1		2141	Dr	Robe	A Siclat		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Ye ar 5:15 P M BENJAMIN 2009 F. BACHE APRIL 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JESSUP ANNE ARUNDEL 7810 CLARK RD. LOT D34 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ፟፟፟∭ M 2 □ F Yrs. Director 1954 215-66-<u>675</u>2 55 17, KENTUCKY FEB. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director MD. ANNE ARUNDEL **JESSUP** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7810 CLARK RD. LOT 20794 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Mi Elementary/Secondary (0-12) College (1-4or 5+) 12 ANIMAL CARETAKER U.S.D.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EARL BACHE CATHRYN DENT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOT D34, JESSUP, MD. 20794 NANCY C. BACHE/WIFE 7810 CLARK RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ott 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-14-2009 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. rambered M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and D months etastotic **Physician** ance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) I∐Yes 2 ☐No detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41139

State Registrar

DHMH 17 Rev 1/2001

11065 LITTLE PATUXENT PARKWAY, COLUMBIA, MD. 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

82. Registrar's Signature

CLEMENT B. KNIGHT,

31. Date filed (Month, Day, Year)

09-03120 Gary Broadwater Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 13768

., -			1- For State Certificate of Registrar	Death	Reg.	No.				
	Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death  Month	Day Year	3. Time of Death 1827 hrs			
	' Exami		Gary DeWayne Broadwater	Out To the of Doot	April 18, 200	4c. County of De				
			4a. Facility Name (if not institution, give substant name)	o. City, Town, or Location of Deat Takoma Park		Montgomer				
			Washington Adventist	If Under 1 Year If Under 24Hr	s 18 Date of Birth		Birthplace (State or			
	Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Mi		For	reign Country) DC			
	Director		212-90-0100 1XM 2F 42 Yrs.		09/01/	1900	- Dodniny, Bo			
	ý	Ī	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits			
	w an	ı	133.34.1				1 Yes 2 X No			
	land f sho	ġ	MD Garrett Grantsvill	10f. Zip Code	100	. Citizen of What C	Country?			
	ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number	21536		USA				
	th the 23a o notifi		3881 Bear Hill Road  11 Marital Status   12 Was Decedent Ever in U.S.   13 War	Decedent of Hispanic Origin? (	Specify Yes or No-		nerican Indian, Black,			
	th wir	Funeral	1 Nove Married 2 Married Armed Forces? If You	es, specify Cuban, Mexican, Puer	to Rican, etc.)	White, et	s.			
	or dea	ᆵ	I Von 2 X No	Yes 2 X No specify:		Specify:	White			
	21215-0036  uld be filed within 72 hours after death with the Maryland hanel Hygiener and "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	by	15 Decedent's Education (Specify only highest grade completed) 16a, Deceden	's Usual Occupation (Give kind o		16b. Kind of Busine	ess/Industry			
	2 hou "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use re	etired)					
9	136 hin 7 e. than	aldu	12 Wastew	ater Operator			Grantsville			
	d wit ygien ygien other	Son	17. Father's Name (First, Middle, Last)	18.Mother's Nar	me (First, Middle, M	aiden Surname)				
	215 be file ntal H rked	Be	Gary D. Broadwater	Eleano	or Sorrel	<u>l</u>	7'- 0-4-)			
	21 ould of Mer of Mer s man	2	19a. Informant's Name/Relationship (Type, Print )	Address (Street and Number of Webster Street	or Rural Route Numb	oer, City or Town, S	2)712			
	MD d 2 sh lth an n 27 i		Gary De Broadward,	ition (Name of cemetery,	Date	20c. Location - Cit				
	re, s l an f Hea If iter		1 V Rurial 2 Cremation 3 Removal from State crematory or ot	ner place) Ar	oril 22,	1.2				
	Page Page nent o		Grantsvil	le Cemetery	2 <b>00</b> 9		ville, MD			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienie Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	lame and Address of Facility	79 Miller	Miller Street				
	<b>ന</b> ഉപ്പ്		23a. Part I. Entir the disease, or complications that caused the death. Do not enter the	antsville, Mary	correspiratory arre	536 st. shock, or heart	Approximate Interval			
	hysician ledical		failure, List only one cause on each line.		o or roophatory arre		Between Onset and Death			
	_xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hemopericardium due to dissect or condition resulting in death)  Due to (or as a consequence of):	tion of the aorta						
			h							
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				1			
		퉅	cause. Enter Underlying Cause (Disease or injury that initiated  C.  Due to (or as a consequence of):							
	ed nsit	Examiner	events resulting in death) Last  Due to (or as a consequence or).			_				
	Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	g	UNPENDED AMENDED							
	760, icate be et physicia the buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	elivery			
	6876 Sertificat ading plh	\frac{1}{2}	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pre	gnancy	Month	Day Year			
	ox 687 ath certifi attending or use as 1	sician	4 Pregnant at time of death 5 0	ther (Specify)						
	Box ne death c the atten		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?			
	P.O. E	J A		underlying dadoo given in t art is			Probably 4 Unknown			
	ords, P.C w requires that as been signed ( should be deta						ere autopsy findings available			
	Cord law req has bee	<u>e</u>			autor		or to completion of cause of ath?			
	Rec The la icate h	Completed				2 No 1	Yes 2 No			
		Be	25. Was case referred to medical	26.Place of Death (Cho		Desidence C	Other:			
	ysi sit		1 Ves 2 No Inpatient 2 VER/Outpatien	IL 3 BOX	ursing Home 5	Residence 6 how injury occurred				
	on of Vital I lending Physician: eath. or: After this certifi the funeral director.			1 Yes 2 No		now injury coconic				
		) i	Natural 5 Pending 2 Accident Investigation		1	Street and Number	or Rural Route Number, City			
	Division of ' Hospital or Attending Ph 24 hours after death. Funeral Director: After 1 rely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	or Town,		<b>5.</b> (1.0.0.)			
	Division Applies or Applies or Applies after meral Director of filled in the	ق	4 Homicide determined (Specify)	Jakita kina data and place	and due to the cau	se(s) and manner a	as stated.			
	To the Hospital within 24 hours To the Funeral			red at the time, date	and place, and du	e to the cause(s)				
	To the within 2	Medical	and manner stated.  29b Signature and title of certifier			(Month, Day, Year)				
		2	220. Digitatore and title of continer		April 19, 200	09				
			Montante Une Sould	O.C.M.E.		1				
		1.	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111	Penn Street, Baltimore, N	MD 21201					
		la	X Marganta North Miles							
		Stat	APR 2 1 2009	del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle Last) 2. Date of Death **Physician** Month 04 Gerald Douglas Borror 23 09 2310 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days Min. Hours 1X M 2 □ F Director 8/28/41 234-62-4859 Keyser. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the "hodical Examiner must be retitined at WV Director Mineral Keyser 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1420 Lynmar Street 26726 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Completed by Specify: 3 Widowed 4 Divorced swinte 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Roy H. Borror Hazel K. Summers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Pfeifle/daughter 1312 Foxfire Dr., Apoka, F1 32712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Run Cemetery 4/27/09 Cabin Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility teves & Markwood Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s certificate 1 □ Yes 1 ☐ Yes 2 ☐ No 2 🗖 (Ño funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation within 24 hours after death.

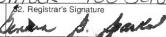
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and the of certifier



and manner stated.

29d. Date signed (Month. Dav. Year)

umberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Bay 8 2009 Clarice Carroll 12:37A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day May 29 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1932 Days, 1 □ M 2 🔽 F Months Hours Min. 218-26-7599 Maryland 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 27 No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Ark Rd. 20711 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Elementary/Secondary (0-12) College (1-4or 5+) 10th 0 Self Employed <u>Duty Nurse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Pratt Cornelia Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wade M. Hall Sr.(Son) 371 Harlem Ave Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion UM Church 4-16-09 Lothian, Md. 21. Signature of Funeral Service Licensee Manual Representations Mortuary, P.A. Larry 821 West St. Annapolis, Md. 21401 10048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Q 54 Due to (or as a donsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

and

Examiner the burial-tran sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Invoical Experiment must be rediffed at

2 should be filed within 72 hours after death with the I n and Mental Hygiene. Is marked other than "naturar", or items 23a or 28a-

Pages 1 and 2 s ment of Health ar ant: If item 27 Is permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.

altimore, Maryland 21215-0036

ģ Completed funeral director, æ Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After this

death.

after death Director:

24 hours a

within 24

filled in by

Medical

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🕅 Inpatient

24a. Was an

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 □Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	
27. Manner of Death	

1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

30. Name and addr

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

ess of person

who completed/cause of death (Item 23a) (Type, Firint)

29c. License number 29d. Date signed (Mon) h, Day, Year)

Year) 31. Date filed (Month, Day,

32. Registrar's Signature

Registrar APR 14 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Samuel Thomas Deeney 10:05a M April 10, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 85 Yrs. 279-46-5243 Director July 9, 1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be available. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏋 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3142 Gracefield Road Apt. MG-105 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2XX Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Thomas Deeney Matilda Stauss ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3142 Gracefield Road Apt. MG-105, Silver Spring, MD 20904 Lorraine E. Deeney / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State April 11, 2009 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 whard Alles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OSTridium **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) 68760, Physician/Medical SE IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation illed in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral Completely filled 29a, Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier ٥ 0036716

State Registrar

Yndrew 31. Date filed (Morlth, Day, Year)

20:01

Box

o 01/1

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Vital

of

3110 Grocefield Road, S: /ver Spring, md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death Reg. No. 1. Deçedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** E EEDER 042 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Yrs **Director** 204-20-6355 80 4, 1928 Sep. Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 XYes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1408 Knights Bridge Funeral 21114 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 natural", or If Yes, Give Year or Dates 1 ☐ Yes 2X No <u>გ</u> Specify: 3 X Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnetic appears." Elementary/Secondary (0-12) College (1-4or 5+) 12 Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Albert Rene Austin 2 Mable Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 York Lane Bowie, MD 20715 Robert Dahms/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/21/2009 Crownsville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Lice 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such 🚜 cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Day Year 5 Other (specify) 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number Name and address of person (Item 23a) (Type, death 10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

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	Funeral			6. Sex 7. A	ige (In yrs. las	st birthday)	If Under 1 Y	'ear	If Under 2	24 Hrs.	8. Date of Birth			place (State o	r Foreign
В	Director		134-10-1247	1 □ M 2 □ X	94	Yrs.	Months D	ays	Hours	Min.	8. Date of Birth (Month, Day Sep 9	, 1914	Cou	place (State of intry) MD	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Loc	eation							10d. Inside Ci	ity Limite
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Baltimore, Maryland 21215-0036	12 mg		19a. Informant's Name/Relationsh Charles Donega		ther	19b. Mailing 1030	Address (St.	reet an est D	ay Ro	r or Rural Dad	Route Number LaVa	r, City or Towr le	, State, Zij	D 215	02
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	b		30. Name and address of person w	ho completed cause of	death (Item 23		rint)		142.00		BURG	24 0			
Sec. 3	Sta Registra		31. Date filed (Month, Day, Year) APR 2 9 2009	32. Registr	rar's Gignatur	are	,	01			00,10	1111	VIII	Ja	
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DHMH 17 Rev 1/2001

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ral tor	-	5. Social Security Number 312-72-7232		7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, D DEC •	irth 3, 1959	9. Birthp Count Indi	
		Usual Residence of Decedent  10a. State 10b. County		10c, City.	Town or Lo	cation				1	0d. Inside City Limit
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	To Be	John Wakeland F					Mar	y Elizabet	h Keslir	ıg	
		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street	and Numb	per or Rural Route Num	ber, Cify or Town	, State, Zip	Code)
		Dawn Ellyn Fish	er, Wife	20h Pl				Logansport	, IN 469		own State
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		21. Signature of Funeral Service I		M01508	2	2. Name and Addre	ess of Facil Mort	tuary Servi LL, Silve	ce, P.A.		20910
		23a. Part 1. Enter the disease, or	complications that ca	used the death.						s, rid	Approximate Interval Between
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ı		resulting in death)	Due to (d	or as a consequ	ence of):						
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		resulting in death) Last	Due to (c	or as a consequ	ence of):						
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	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?								ate of delivionth	ery Day Year
	þ	Part II. Other significant conditi	ons contributing to de	eath but not resu	ulting in the	underlying cause g	jiven in Par				the cause of death?
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							00 Pl	1 XYes	2 🗌 No	1  Yes	2 No
	To Be	<ul><li>25. Was case referred to medical examiner?</li><li>1 ☐ Yes 2 ☑ No</li></ul>	11. 11. 1	npatient 2 🗆 E	ER/Outpatie	nt 3 🗆 DOA Oti		e of Death (Check only lursing Home 5 Re		ther (Specif	(y)
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	Me	29b. Signature and title of certifie	r .			29c. Licens			29d. Date sign	ed (Month,	Day, Year)
1		Mandi	, MO.			KE	5-00	00	[April	8,2	009
		30. Name and address of person  May: (Thirds	who completed caus	e of death (Item	1 23a) (Type	, Print)		600 North W	olfe St. B	altimo	re, MD, 212

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#5perINF,4-20-09,BMW,MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeanne L. Gewain April 10, 0045 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital Montgomery Olney 5. Social Security-Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) PA Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖺 F Months Days Hours Min 80 PA Director July 31, 1928 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the Modical Evanti at must be notified at MD Montgomery Olney Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Riverton Court 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. In the second once. 1 ☐ Yes 2 D If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No White ģ Specify 3 M Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Savidge Miriam Yost ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Matthew Gewain / Son 4 Valinor Road, Hillsborough, NJ 08844 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State April 11, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Examir and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as esn If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes Certification: To 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral di Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) ٩ D0037930 cause of death (Item 23a) (Type, Print) Robert H. Knitzer,
Suite 204 6LNEY, WID 20 30. Name and address of person who completed 3416 OLANDWOOD C 2083

State

Registrar

31. Date filed (Month, Day, Year)

APR

13

2009

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11:25 pM Tae Kyong Hahn April 80 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F 88 Director 169-40-8972 December 13, 1920 China Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 x No 28a-f Maryland Montgomery **Rockville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 6030 California Circle, Apt. 215 20852 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedo... Armed Forces? 1 □Yes 2 🔼 No Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ö 1 ☐Yes 2 No Specify: þ 3 ₩ Widowed 4 □ Divorced "natural" Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Baptist Church 4 Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Chul Woon Habn Jin Jin Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone. David D. Hahn - Son 250 Canyon Lakes Place, San Ramon, California 94582 Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 04/11/2009 Olney, Maryland 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** 21. Signmut of Fund 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Immediate Cause (Final Physician Acute Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami sician and burial-trant Cholecystitis Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Ö ed by the 9 Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy Physiclan: The perform 2 □ No 2 🛭 No 1 ☐ Yes 1 ☐ Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 X Natural Injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ane 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Santosh Rane, M.D.,

13

31. Date filed (Month, Day, Year)

9901 Medical Center Drive, Rockville, Maryland 20850

Registrar's Signature

			1- State of Maryland / Dep. Registrar Ce	artment of Health and <i>rtificate of Death</i>		giene 2009 13777
	Physicia		1. Decedent's Name (First, Middle, Last) Richard C. Hosier		2. Date of Dea	th 3. Time of Death 2048 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Dec	ath	4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577 42 7855 TXM 2 F 82 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthplace (State or Foreign Washington DC
	ryland show	<b>3</b>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo Maryland Prince George; Dist	ocation rict Heights		10d. Inside City Limits 1 □ Yes 2 1 No
	ith the Ma or 28a-f s	Director	Maryland Prince George;s Dist  10e. Street and Number 7209 Lansdale Street	10f. Zip Code 20747		10g. Citizen of What Country? United States
J36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show officel Eventiner nust be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur		
1215-0036	rithin 72 hou ne. han "natura hadical E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation b kind of work done during most of w DO NOT use retired) entific Illustra	16b. Kind of Business/Industry  US Dept of Navy	
yland 2	id be filed within ental Hygiene. ked other than " ic event, In Me	To Be Co	17. Father's Name (First, Middle, Last) Russell C. Hosier	18. Mother's N	ame (First, Middle, el L. Hen	Maiden Surname)
Mary	nd 2 should lith and Mer 27 is marke r traumatic	-	77.77. 77 (0)	ing Address <i>(Street and Number or</i>		r, City or Town, State, Zip Code) .ct Heights, MD20747
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tr		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition of Disposition	osition (Name of matory or other plate) ril 23	, ^D 21009	20c. Location - City or Town, State Cheltenham, MD
Balti	permit. Page: Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee \ \mo1533   2	2. Name and Address of Facility Le	e Funeral	. Home,Inc 6633 01d
i de	Physician	£ 13	23a. Part 1. Enter the disease, o complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as card	liac or respiratory and	rest, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1800/14 166	met	rilece
15	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	1. Please	ecet	min
8/60,	ficate be executed physician and s the burial-transit	edical Ex	resulting in death) Last  Due to (or as a consequence of):  d.	Hepperka	stin	
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ds, P	requires that the peen signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the L	inderlying cause given in Part I.		obacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 ☑ Unknown
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lon ot	nding Ph ath. r: After th e funeral	ation: T	27. Manner of Death 1	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred
DIVISION	ai or Atte s after dea ii Directol ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, rn, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, it	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal can be compared to the basis of examination and/or in and manner stated.			
<b>A</b>	To the within To the comp	Me	29b. Signature and title of certifier  Mules Could Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dimensional Dim	29c. License number  D00247496		29d. Date signed (Month, Day, Year)
(	NR 1851		30. Name and address of person who completed cause of death (Item 23a) (Type,	1	Pisen	MINO 20731
Í	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	barres		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 ner fh 9891 5-5-09 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:44A M Francis A. Jones April 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 5097 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 🔀 M 2 🗆 F Months Days Director 215-34-<del>5095</del> 04/17/1939 70 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Exaction 10 to 10 to 11 the London. Be Completed by Funeral Director 1 Yes 2 □ No MD Harkord Havre de Grace 10g. Citizen of What Country? 10e. Street and Number U.S.A. 316 South Juniata Street 21078 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service 12 Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Austin H. Jones Margaret E. Rink ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Chestnut Street, Aberdeen, Maryland 21001 Mary F. Jones (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris &Co., Inc. 04/25/2009 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licensee 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final disease or condition resulting in death) BLEZED - SPONTANEOUS 72 hoves **Physician** INTRACEREBRA /Medical Due to (or as a consequence of): Examiner YEAR HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE f yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩o 24a. Was an autopsy performed? To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D0056296

poerchesapeake prive Bel Air, mp 21014

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month PRIL /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City. Town, or Location of Death Novien 5. Social Security Number If Under 24 Hrs. f Unde **Funeral** 7. Age (In yrs. last birth r 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours XXM 2□F Months 188 48 3411 Yrs Director 52 9/8/1956 <u>Pennsylvania</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercitive rough be notified at Director 1 □Yes 2 □ No Maryland St. Mary 's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21612 Liberty Street 20653 Funeral United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 📆 🏋 o ò Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienc Important: If Item 27 Is marked other that any Injury or other traumatic event, the 1 once. Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Jackson, Sr. ပ Mabel (Unknow) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Jackson (Wife) 21612 Liberty Street, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory April 13, 2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Sico Alexandira Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset and Death Immediate Cause (Final **Physician** ONGOSTI disease or condition resulting in death) MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the ceath certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending ph for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 has been signed 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate ha 1 □Yes 2 □ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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d address of person who

APR 15 2009

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen			and M	lental Hy	/gien	2001	Q	13780
	Physic		1. Decedent's Name (First, Middle, Las Vladimir Mikulas	*						2. Date of De Month April	eath		ar	3. Time of Death 12:15 A M
	/Medi Examir		4a. Facility Name (If not institution, give			Poto	4b. City, Town, or Location of Death Potomac				4c. Count Mont			
	Funeral Director		5. Social Security Number 579–48–9869 10  Usual Residence of Decedent	6. Sex  7. Age (In yrs. last birthday)  1 1 1 Yrs.  91 Yrs.			Months Days Hours Min.				rth a <i>y, Year,</i> 1918			lace (State or Foreign htry) 10s1ovakia
	Maryland a-f show	ctor	10a. State 10b. County  MD Montgome	ry	10c. City, Town or L Bethesda								1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith with the 23a or 28 1st be no	al Director	10e. Street and Number 4952 Sentinel Dri			10f. Zip	Code 0816					itizen of Wha		
9036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural" or Items 23a or 28a-f show evant, the Modicel Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Deced If Yes, spec			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, V Specify: W	White,	etc.
21215-0036	e filed within 72 h al Hygiene. I other then "netu vent, Ine Madical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5- 5+	(Give	dent's Usua kind of wo DO NOT us Exect	rk done d se retired	lu <i>ring m</i> osi )			Uni	Cind of Busin ted Na ernati	itic	
yland	should be filed ind Mental Hygis s marked othar umatic evant, IL	To Be C	17. Father's Name (First, Middle, Last) Vladimir Kabes					Mila	da B	(First, Middle 1echa				
re, Mar	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		Otilia Marie Kabe.  20a. Method of Disposition	s / Spouse	20b. Place of Dispe	Sent:	inel	Dr.	#401	Bethes  Date	sda,		816	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra: <u>once.</u>		1 ☐ Burial 2 又 Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	•		Crema 2. Name an	atory d Addres	y s of Facilit	Jose	/2009 eph Gaw	ler		s I	nc.
ľ,	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Sepsis						NW Was		geom,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to the steep signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pisease or injury that initiated events resulting in death) Last	Volume  Due to (or as a  End Sta	Depletion consequence of): ge Heart consequence of):	Failu:	re						W	leek
.O. Box 6	that the death certific led by the attending p detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 ☐ Fetal death 3 ☐	∃Ectopic pro ∃ Other (sp						23d. Date of Month		ry Day Year
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Division of Vital	ling Phys n. After this funeral di	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1  Inpatien 28a. Date of Injury (Month, Day	/ 28b. Time o		8c. Injury Work	r: 4 🛣 Nui	rsing Hor	ne 5 ☐ Resi	dence		Specify	)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:20 PM April 17, 2009 Jean Kisner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center 0akland Garrett Oakland Nursing & Rehab. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2][[] F 9/27/1924 Director Maryland 216-3<u>8-2009</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Modical Examinating the Inditional anone. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Friendsville Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21531 U.S.A. 1218 Kisner Road ieted by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4or 5+) Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Humberson Mae Oliver В. Frazee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1164 Kisner Rd., Friendsville, MD 21531 Patricia Kisner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 4/20/09 Friendsville, MD Humberson Cem. 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD21536 er 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) 5245 Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Physic 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of atural Accident

**Examiner** certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760 attending physician this funeral Hospitel or Attending Pl 24 hours after death. 8 Funerel Director: After the Certification: within 24 hours a To the Funerel C

Baltimore, Maryland 21215-0036

5 Pending investigation

6 ☐ Could not be determined

3 Suicide

29a. Certifier

cai

10

4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fourth St., Oakland, MD 21550 311 N Thomas Johnson M.D. 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No: 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 10:28a™ April 16, 2009 MARY ESTER KEMPHFER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Garrett Garrett County Memorial Hospital Oakland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number

10c. City, Town or Location

Oakland

12/30/1915

MD

10d. Inside City Limits

17 Yes 2 ☐ No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rigitified at once. Baltimore, Maryland 21215-0036

1 - For State Registra

10a. State

218-16-3472

10b. County

Garrett

Usual Residence of Decedent

1□M 2√□F

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical **Examiner** 

physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed t icate has been significate yage 2 should b within 24 hours after death.

To the Funerel Director: All completely filled in by the fu

Ş	MD Garre	ett 0	akland				X Yes 2 No						
Je C	10e. Street and Number		10f. Zip Code		10g. Citiz	zen of What Coun	ntry?						
<u></u>	706 East Alde	er Street	21550	0	U.	S.							
Der	11, Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of If Yes, specify Cub	es or No-	14. Race - Americ Black, White,								
by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 分 Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes ŽÇXvo				ite						
Completed	15. Decedent's E (Specify only highest g	Education rade completed)	16a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	pation during most of working	16b. Kir	nd of Business/Inc	dustry						
dwo	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Homemak			omesti	C						
BeC	17. Father's Name (First, Middle, Las	st)		18. Mother's Name (First,	Middle, Maiden	Sumame)							
To B	Gilbert Lowde	ermilk		Bessie Ca	steel I	owderm	ilk						
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Stree	t and Number or Rural Route	Number, City o	r Town, State, Zip	Code)						
	Paul Kemphfer	:/Son	115 Highlar	nd Ave., Te	rra ALt	a, WV	26764						
	20a. Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other (Spec	□Removal from State	lace of Disposition (Name of emetery, crematory or other place kland Cemete	1		akland,							
Suc	21. Signature of Funeral Service Lice	ensee	22. Name and Addr Arthur F 105 High	ess of Facility H. Wright Finland Ave.,	uneral Terra	Home Alta, W	N 26764						
	23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death y one cause on each line.		ing, such as cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death						
in al	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	systolic he	aut failure			48 hr						
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Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delive Month											
d by Ph	Part II. Other significant conditions	3e. Did tobacco t	cco use contribute to the cause of death?										
ompleted		24a. Was an autopsy performer											
0	25. Was case referred to medical			26. Place of Death (Che									
0		Hospital: 2 patient 2	ER/Outpatient 3 □ DOA	ther: 4 Nursing Home 5	Residence	6 ☐Other (Speci	fy)						
atlon; T	27. Manner of De th  1 Natural 5 Pending 2 Accident investigat	28a. Dife of Injury (Month, Day Year)	28b. Time of lnjury 28c. Inj		escribe how inju								
ertifica	3 Suicide 6 Could not 4 Homicide determine		ome, farm, street, factory, office		ocation (Street ari ity or Town, State	nd Number or Run 9)	al Route Number,						
Medical Certification:	29a. Certifier Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, and du opinion, death occurred at t	e to the cause(s)	) and manner as s d place, and due t	stated. to the cause(s)						
W	29b. Signature/and title of certifier	atain 1	29c. Lice	16650	. 1	tte signed (Month,							
1	margaret a Ka	to completed cause of death (liter	88 Memorial	Chiese O	alilane	d, No	21550						
State	31. Date iled (Month, Day, Year)	32. Registrar's Signa	ature										

Registrar

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Physic /Medi		Clayton Owen Katski			3 1	18 09 9:10 A M
Exami	ner	4a. Fecility Name (If not institution, give street and number	or)	4b. City, Town, or Location of Dea		4c. County of Death
		7316 Casey Ave.  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday,	Easton If Under 1 Year If Under 24 Hrs		Talbot  9. Birthplace (State or Foreign
Funeral Director		219-12-3327	84 Yrs.	Months Days Hours Min		country)
land ow		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
Many Feb	to	Md Talbot	Easton			1 ☐ Yes 2 ☐ No
h the	lrec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
ith wil	a	7316 Casey Ave.		21601	US	SA
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	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40)	(Give life.	odent's Usual Decupation a kind of work done during most of we DO NOT use retired)	orking	b. Kind of Business/Industry
Hygie ther ther	ပိ	12 17. Father's Name (First, Middle, Last)	Elec	trial Contract	or First, Middle, Maid	Electric den Sumame)
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shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or F		ty or Town, State, Zip Code)
is 1 and 2 of Health a ltem 27 is		Susan Lynch (daughter	7204	Bobs Way East	on, Md. 21	601
permit. Pages 1 ar Department of Hea Importent: If Item 5 eny Injury or other page.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	21-09 Do	Dover, De.		
Depart Import eny In		21. Signature of Funeral Service Licensee  Hull  23a. Part1. Enter the disease, or complications that cause		2. Name and Address of Facility R. Carroll Hu		
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Physic this c	2		atient 2 EP/Outpatie		71	6 Other (Specify)
ending I eath. or: After the funer	atlon	2 Accident investigation	njury 28b. Time o Da <i>y Year)</i> Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how i	njury occurred
2 4 5 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building.	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the beside and paginer.	of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier  Funt  Fund	ıı	29c. License number  De0 5 7 9 0 5	_	Date signed (Month, Day, Year) 3/20/09
		30. Name and address of person who completed cause of Robert J. Patterson		•	, St. Mic	haels, MD.21663
St	ate	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature			
Regist	-	APR 2 9 2009	enna A.	parte		

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	I / Depa	artment		and Me	ntal Hygi	ene	.g.i.g.o.	1010	
			Registrar  1. Decedent's Name (First, Middle, Last)			incate	Of Dealif		Date of Death	g. No.		3. Time of Death	
	Physici		Donald Lee Kis	or					Month	Day	Year	М	
20.0	/Medio Examin		4a. Facility Name (If not institution, give st			4b. City, To	wn, or Location		ri1 22	22, 2009 11:27 A			
	Ladiiii	C.				Cumb	erland				Legany		
I	Funeral		Memorial Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1	Year If Under Days Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)		place (State or Foreign	
	Director		236 - 44 - 7090 Usual Residence of Decedent	^{M 2□F} 83	Yrs.		,,	7	/30/25	5		ser, WV	
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation					1	10d. Inside City Limits	
	Mary Frsh	ţo	WV Minera	l Ke	yser							1 ∐Yes 2 k∏ No	
	or 28	Director	10e. Street and Number			10f. Zip C			10	g. Citizen	. Citizen of What Country?		
	23a (23a ust b	ral	HC 72 Box 12			26	726			U.S	.S.A.		
	er dea tems hvr tu	Funeral	Thanks outs	2. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Deceder f Yes, specify	nt of Hispanic Or Cuban, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		Race - Ameri Black, White,		
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Everninal coust by rediffed at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1y∏Yes 2 ☐ No If Yes, Give Year or Dates:	1	l∐Yes <b>X</b> [	No Specify:			Spi	_{ecify:} whi	te	
215-0036	2 hou atura		15. Decedent's Educa	ition	16a. Deced	dent's Usual (	Occupation		1		of Business/In		
2	thin 7 ne. an "n	Completed	(Specify only highest grade ( Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use	done during mos retired)	st of working					
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yıand	I be fil intal F ed ott	Be	17. Father's Name (First, Middle, Last) Charles E. Kise	er. Sr.				er's Name (F ude B	irst, Middle, M. lair	aiden Sur	name)		
2	should nd Me mark matic	ျ	19a. Informant's Name/Relationship (Type		19b Mailin	n Address (S	Street and Number			City or To	iwn State Zii	n Code)	
Z Z	nd 2 salth au 27 ls 27 ls rtrau		Patricia Kiser			,				,	5726 ocation - City or Town, State		
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Ĕ	Page ment ant: It ury o		<b>X</b> ☐ Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	noval nom State			nt Cem.	4/26	/09   K	(evs	er. W	V	
Бантіто	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Moderi Evantion must be refilled at once.		21. Signature of Funeral Service Licensee		22	. Name and	Address of Facility of Fune	ty		-3			
_	2.C1 = 16 OI		23a. Part 1. Enter the disease, or complica	Ce Junger	P	. O. B	912	, Key	ser, W	IV 2	6 <del>726</del>		
		8 6	shock, or heart failure. List only one Immediate Cause (Final									Approximate Interval Between Onset and Death	
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XOC	anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregnan		1				23d.	Date of deliv	ery	
0	death	icia	in the past 12 months? 1 □Yes 2 □No	1 Live birth 2 Fetal of 4 Pregnant at time of dea		] Ectopic preç ] Other <i>(spe</i> c					Month	Day Year	
ר כ	at the	Physician/Med	9 Unknown										
<u>ה</u>	signed be de	þ	Part II. Other significant conditions control.  Chronic Alai		ing in the un Katro		se given in Part I.	.				he cause of death?	
ecords,	been should	Completed		04 1.8W	Marrie							bably 4 Onknown	
ž .	e has ge 2 s	d m							24a. Was an autopsy perform			opsy findings available empletion of cause of	
<u>.</u>	an: II tiflicate or, pa	ပ္ပ	25. Was case referred to medical				OC Dines	of Dooth (C	1 □ Yes 2	₩o	1 ☐ Yes	2 🗆 No	
<b>&gt;</b> :	ysicia is cer direct	0 0	examiner?	spital: 1 npatient 2 E	R/Outpatien	t 3 □ DOA	Other:		5 ☐ Residen		Other (Specia	f ₍ )	
5 7	ng r.n fter th neral	T:UC	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	<del></del>	8b. Time of Injury		Injury at Work?		. Describe how				
	eath. or: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be		-	М	1 □ Yes 2 □	No					
<u> </u>	or Ar after d Direct in by	ertification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, of	fice	28f.	Location (Stre City or Town,	eet and No State)	umber or Rura	al Route Number,	
	spital lours and neral rilled	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29a. Certifier (Check only one)  29d. Date signed (Month. Day, Year)											
	To the crospital or Attending Prlysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit												
	vithi To the	Ž	29b. Signature and title of certifier	0 11-		29c. L	icense number		290	d. Date si	gned (Month,	Day, Year)	
			-tendos.	191 L	ر 	D6	5070		Ар	ril	22	2009	
•	12		30. Name and address of person who com MADHUSUDHAN				4 -1		. ^		,		
	-	te	31. Date filed riphyntin Day, March O	32. Registrar's agnatu		100	7640	U AL	ive C	umb	erland	L, MD. 21502	

Registrar

	Plea	se Type or								egible.	
For State Registrar		State o	of Maryland		artment : rtificate			lental Hygid Red	ene	009	13785
1. Decedent's Nam	e (First, Middle	e, Last)						2. Date of Death	Lan	. 0 0 0	3. Time of Death
		Mon Suey	Lee					Month April	Day <b>08</b>	Ye ar <b>2009</b>	1:07 aM
4a. Facility Name (	f not institution	n, give street and nu			4b. City, To	wn, or Loca	ation of Death		4c. C	ounty of Deat	h
Mon	teomety (	General Hos	nital			01	ney			Monte	gomery
5. Social Security N		6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	Year If t	Jnder 24 Hrs.	8. Date of Birth (Month, Day, Y	(ear)	9. Birtl	hplace (State or Foreign
577-48-0	563	1 <b>⊠</b> M 2□ F	88	Yrs.	Months [	Days H	ours Min.	March 31,			China
Usual Residence o											10.1 1. 1. 61. 1. 1.
10a. State	10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Maryland	М	ontgomery					Spring				
10e. Street and Nu	mber				10f. Zip C	ode		100	g. Citize	en of What Co	untry?
3527 T	arkingto	n Lane, #63	A			20	906			U.S.	Α
11. Marital Status		Armed F		3. 13.	Was Deceder If Yes, specify	nt of Hispar y Cuban, M	nic Origin? (Sp lexican, Puerto	pecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ame Black, White</li> </ol>	
1 Never Marr		ied 1 ▼Yes If Yes, G	2 □ No ive		1 □Yes 2 🖸	X No Sp	pecify:			Specify:	
3 Widowed		Year or I						1			Asian
(Spe	15. Deceden	t's Education st grade completed,		(Give	dent's Usual ( kind of work	done during	ı g most of work		Sb. Kind	d of Business/I	Industry
Elementary/Seco	ondary (0-12)	College (	1-4or 5+)	life.	DO NOT use					D-4	-21
1.2	/Figure Adjusted to	( pot)			Busin	ess Ow		e (First, Middle, Ma	iden S		ail
17. Father's Name						10.	WOUTET 3 TAGIT				
	Kung Han			T 40h 14-111-	//	Ot	Number of Div	Tom Shee			Zin Codo)
19a. Informant's N											ip Code)
20a. Method of Dis	oy - Dau	gnter	20h Pl		sition (Name		-	lle, Maryla		20853 ation - City or	Town, State
1 🗷 Burial		3 ☐ Removal from pecify)	State	emetery, crer	natory or othe ven Cem	er place)	1			,	, Maryland
21. Signature of Fi	ineral Service	Licensee	مت	Hj		aldi F	uneral H	ome, Inc. nue, Silver	Spr	ing, Mar	yland 20904
shock, or hea Immediate Cause	rt failure. Lis	complications that only one cause on	each line.		ter the mode	of dying, su	uch as cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death
disease or condition resulting in death)		-	Due to (or as a consequence of):								6 Hours
Sequentially list co	nditions	b									
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	eriying injury	Due to	Due to (or as a consequence of):								
that initiated event resulting in death)	s Last	c Due to	(or as a consequ	ence of):							
		d									
IF FEMALE: 23b. Was deceder	t pregnant		itcome of pregna		7				23	3d. Date of del	ivery
in the past 12 1 ☐ Yes 2	: months? □No		birth 2□Fetal gnant at time of d nown		☐ Ectopic pred ☐ Other (spec					Month	Day Year
9 Unknown			danata bara makanan	lain - in Alma v	malauli dan ara	on -lune in	Doet I	220 Did toba		e contribute to	the cause of death?
11	,	ons contributing to	death but not resu	liting in the u	nderlying cau	ise given in	Part I.				
Hyper	ensis n							1 L Yes	2 1	<b>⊬</b> 70 3∐ Pr	obably 4 Unknown
ANEMI	7		91					24a. Was an autopsy performe	ed?	prior to death?	topsy findings available completion of cause of
								1 ☐ Yes 2		1 ☐ Yes	2 DHV0
25. Was case refe examiner?		Hospital:				Other-		th (Check only one)			
1 Yes 2			Inpatient 2 🔽	ER/Outpatie 28b. Time o	-	٠	1 ☐ Nursing H	ome 5 Residen			cify)
27. Manner of Dea 1 ☐ Natural 2 ☐ Accident	th 5 ☐ Pendin investi	ig (Mo	e of Injury nth, Day, Year)	Injury	M 280	c. Injury at Work? 1 □Yes	2 🗆 No	28d. Describe how	injury	occurred	
3 Suicide 4 Homicide	6	not be 28e. Place build	e of Injury - At ho ding, etc. <i>(Specif</i> y	me, farm, str	eet, factory, o	office		28f. Location (Stre City or Town,		Number or Ru	ural Route Number,
29a. Certifier	1 Certifyii	ng Physician: To th	e best of my know	wledge, deat	h occurred at	t the time.	date and place	and due to the car	use(s)	and manner as	s stated.

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year) 3 1

29b. Signature and title of certifier

(Check only one)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

118726

29d. Date signed (Month, Day, Year)

OLNEY, MD 20832

			For State Registrar		State of M	Maryland		artment of F rtificate of	lealth and N <i>Death</i>		gien Reg. N	711119	13786	
	Physici	20	1. Decedent's Nam	e (First, Middle, La	ist)					2. Date of De Month	ath Da	ay Year	3. Time of Death	
	/Medic			rey McCa						April	10,	2009	3:20a M	
	Examin	er		lf not institution, giv Deerhurst To	e street and numbe errace	r)			r Location of Death <b>er Spring</b>		40	County of Death Montgomer		
	Funeral Director		5. Social Security N 578–44–303		Sex 7. A	Age (In yrs. Ia:	st birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birth Cou	pplace (State or Foreign intry) Ireland	
	p.		Usual Residence o			140.00							10d. Inside City Limits	
	laryla shov	or	10a. State	10b. County  Montgome	2757	10c. City,	Town or Lo	ver Spring		1 □ Y				
	the M	Director	10e. Street and Nu		<u></u>			10f. Zip Code			10q. C	itizen of What Cou	Intry?	
	h with			rhurst Ter	race				0906		J	USA	,	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Eventine It ust be notified at once.	d by Funeral	11. Marital Status 1 ☐ Never Marr 3 🏋 Widowed	rled 2 Married	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? <b>₫</b> No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 <b>X</b> No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)	)-	14. Race - Amer Black, White, Specify: Wh		
5-0	72 hu "natu	letec	(Spe	15. Decedent's E cify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	king	16b. I	Kind of Business/li	ndustry	
121	within ene. <b>than</b>	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	r 5+)		cered Nurse				Health Car	æ	
9	ifiled Hygi other ent, I	Be C	17. Father's Name	(First, Middle, Last					18. Mother's Nam	ne (First, Middle,	, Maide	n Surname)		
/lar	uld be Menta Irked Itic ev	일	Corneliu	as Carey					Eliz	zabeth O'I	3rier	า		
, Mar	and 2 sho ealth and n 27 is ma		19a. Informant's N Anne M. C	ame/Relationship	(Type. Print) aughter				and Number or Ru e, Hyattsvi				ip Code)	
Baltimore, Maryland 21215-0036	Pages 1 ament of He ant; If iten ury or oth			•	Removal from State	e i		sition (Name of matory or other plac ven Cemeter	· Δ101011 I	Date 15, 2009		ocation - City or T Lver Spring		
Balt	permit. F Departme Importan any Injur		21. Signature of Fi	uneral Service Lice	Arealo		22	2. Name and Addre Francis J 500 Unive	ss of Facility • Collins E ersity Blvd.	Tuneral Ho West, Si	ome 1 ilver	Inc. Spring, M	ID 20901	
	Physician /Medical Examiner		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final on	Due to (or a	line.  on stiv	e <b>Hear</b>	t Failure	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Conset and Death 3 months	
4		ner	Sequentially list co	inditions,		s a conseque		Disease					icais	
6	ificate be executed g physician and ts the burial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury	cAt	theroscl	erotic	Cardiovasc	ular Diseas	se .			Years	
30,	oe execian a	Ĕ	resulting in death)	Last	Due to (or a	is a conseque	ence of):							
68760,	ficate I physi s the b	edical			d									
O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X□ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown									23d. Date of delive Month	very Day Year	
σ,	s that med b	by Pt			contributing to death	but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?	
ord	w requires been sign should be		Rhe	eumatoid Ar	thritis					1 🗆 '	Yes 2	2 <b>X</b> No 3□ Pro	bably 4 ☐ Unknown	
of Vital Records,		Completed	Chr	ronic Kidne	y Disease			-		24a. Was autop perfo 1 □Yes	osy rmed?	prior to co death?	opsy findings available ompletion of cause of	
/ita	sician: The la certificate ha rector, page 2	Be C	25. Was case referexaminer?						26. Place of Dear					
of \	Physi this o		1  Yes 2			tient 2 E			4 LI Nuising H		_	6 ☐ Other (Spec	ify)	
on	ding h. After funer	Certification: To	27. Manner of Deat	tn 5 □ Pending investigatio	28a. Date of In (Month, E	Day, Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe I	how inju	ury occurred		
Division	Attendir death.	fica	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e 28e. Place of I	njury - At hom	ne, farm, str	eet, factory, office	103 2	28f. Location (	Street a	and Number or Rui	ral Route Number,	
Ö	al or safter safter al Dire	Serti	4 ☐ Homicide	determined	building, e	etc. (Specify)				City or To	wn, Stat	te)		
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)	1⊠ Certifying P 2☐ Medical Exa	hysician: To the bes miner: On the basis and manners	of examination	ledge, deatl on and/or in	h occurred at the tivestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause( date ar	(s) and manner as nd place, and due	stated. to the cause(s)	
	vithii To th	ž	29b. Signature an	title of certifier	21/			29c. Licens D3203			29d. D.	ate signed (Month April 10,		
	12		•	teo	14	m						WATTI TO,	2003	
			30. Name and add		completed cause of 5530 Wisco	,		^{Print)} Chevy Chase	MD 20815					
	Sta	te	31. Date filed (Mor		32. Regis	strar's Signatu	re	*						
,	Registr		AP	R 13 200	19 Gentur	J.	face	Kad.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:04 P M **BETTY FAYE** MELBOURNE APRIL 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs Director 250-42-1113 29, 1931 SOUTH CAROLINA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 X Yes 2 No MD. PRINCE GEORGES HYATTSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 OLIVER ST. 20782 by Funeral Pages 1 and 2 should be filed within 72 hours after death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 XNo Specify: 3 ☐ Widowed 4 🔯 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည **EMORY** MAHUE SLICE ORA MAE HITE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REITMANN/FRIEND GRETA J. 3915 OLIVER ST., HYATTSVILLE, MD. 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 4-15-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A WM Chamberry M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1∐Yes 2 No g Unknown g 🗌 Unknown signed by to d be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown s been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has this certificate 1 □Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division To the Hospital within 24 hours a To the Funeral I 3

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, Manylond 7600 Carroll Avenue, TERRY JODRIE 2. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar 29b. Signature

nd title of certifier

500 pts

29c. License number

D40324

29d. Date signed (Month, Day, Year)

APRIL 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 12:25 George Joseph Meiburger <u>April</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Casey House Rockville Montgomery f Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 🔀 M 2 🗆 F Director 87 14. 1921 Missouri 495-12-0196 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, for Medical Evanting must be notified anonge. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Chevy Chase 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5555 Friendship Blvd. # 324 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2K Married 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Strope Henry Meiburger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Meiburger 23504 Puritan Place Damascus. Md 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/11/09___ National Crematory Falls Church, Va. 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Lipanse 5130 Wisconsin Ave N.W. Washington D.C. 20016 23a. Part 1. Enter the district se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail. In . List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) P.O. ned by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 ☐ Yes 24 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA မှ 1 Inpatient Division of 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 1 🛮 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D29353 04/10/2009 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) George Graves MD 5530 Wisconsin Ave. #1400 Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) Registrar's Signature State 13 2009 Registrar

DHMH 17 Rev 1/2001

	1	For State Registrar	9	State of	Marylan	nd / Depa <i>Cei</i>	artmen rtificat				lental Hy	ygiene Reg. No.	/ / /	09	3	789
Physiciai /Medica	1	1. Decedent's Name (First, Middle Hazel Marie		rris							2. Date of D Month 04	eath 15	, O	Year 19	3. Time of D	eath M
Examine	r	4a. Facility Name (If not institution WMHS BRADDOC  5. Social Security Number	_	MPUS		la at hirthday)		JMBEI	Location RLAND If Under	)	9. Date of B		County o	GANY	lace (State or	Foreign
Director		220–48–9512 Usual Residence of Decedent		1 2 🔀 F	91	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D April	22 1	917	Mary	rland	r-oreign
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permi Depar Impor any ir		21. Signature of Funeral Service L	el L	Bool		1	11 Ch	urch	St,	West	al Fun ernpor	t, Ma			21562	
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List ( Immediate Cause (Final disease or condition resulting in death)	complicationly one of	ac	- Andrews	myor			g, such as	s cardiac o	or respiratory	arrest,			Approximate Interval Betwood Onset and De	een eath
Examiner	iner	Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Common Out to (or as a consequence of):  c. Due to (or as a consequence of):  d.								lige	20				Yen	7
e cia	icai Exa															
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemination and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event, the Michael Exemplation and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic ev	Physician/ined	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown											I. Date of delivery Month Day Year			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 04 09 2145 Franklin James Murray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WMHS BRADDOCK CAMPUS CUMBERLAND 8. Date of Birth (Month, Day, Ye Oct. 26, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Min. Hours Months Days 1**X**]M 2∏ F 1923 Pennsylvania 85 208-22-9894 Director Usual Besidence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examinar must be modified at 1 ☐ Yes 2 ☑ No Director Salisbury PA Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15558 USA 209 Murray Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self-employed Auctioneering permit. Pages 1 and 2 should be filed wir Department of Health and Mental hygien Important; If Item 27 is marked other the any injury or other traumatic event ***** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Fuller ဂ Clay Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Murray Rd., Salisbury, PA 15558 Ellen E. Murray/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State April 17, 2009 Meyersdale, PA Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Fungral Service Licensee ix P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONCESTIVE Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a ☐Yes 2☐No 9 HInknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 2 □ No 1 ☐ Yes certificate 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Denpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Matural n 24 hours after death, le Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completely f

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

7them 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

U 935 S 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D 26907

29d. Date signed (Month, Day, Year)

Drive Cumberland, MD 21502

amend #Jease Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 200°9 Rita J. Meredith Apri1 7:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Queen Anne Centreville Oueen Anne's 5. Social Security Number 2019 If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🔀 F 55 Maryland 212-66-Mar 1954 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov idioal Exar, incrinist by rigitled at or 28a-f shov Maryland Oueen Anne's 1 ☐ Yes 2 No Grasonville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3231 Main St. 21638 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married ☐Yes 2☐No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: þ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Mang. Elementary/Secondary (0-12) College (1-4or 5+) 12th 1yr McDonald's Corp. Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eldridge Meredith Sr. ပ Margaret A. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Meredith (Mother) 3231 Main St. Grasonville, Md. 21638 20a. Method of Disposition 20c. Location - City or Town, State 20bj Place of Disposition (Name of Demeter) crematory or either place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U.M. Church 4-13-09 Chester, Md. 21. Signature of Funeral Service Licensee And the Angeles of RecilitSons Mortuary, P.A. La 821 West St. Annapolis, Md. 21401 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** etastatic 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any learning to trimmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy certificate Ž**V**□No 1 ☐ Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \subseteq \) Nursing Home \( 5 \subseteq \) Residence \( 6 \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 147232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Spencer DeShields, Street Suite 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last)

Months

4b. City, Town, or Location of Death

Lanham If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. |

Days

3. Time of Death

6:10 P M

9. Birthplace (State or Foreign Country)
D.C.

10d. Inside City Limits

1 ☐ Yes 2**X**☐ No

Day

April

8. Date of Birth (Month, Day, Feb 6

2009

Prince George's

14. Race - American Indian,

Specify: Black

21401

23d. Date of delivery

1 ☐ Yes

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 □No

Year

Month

4c. County of Death

USA

**Physician** /Medical Examiner

James V. Mason

5. Social Security Number

10a State

579-56-7547

Usual Residence of Decedent

9108 Tallfield Ct.

10b. County

Maryland Prince George's

4a. Facility Name (If not institution, give street and number)

TY□ M 2□ F

**Funeral** Director

show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exercites in 4st by restlined at and Mental Hygiene.

within 72 hours after

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau **Physician** /Medical Examiner

g physician and strans attending plant for use as as ned by the signed t peen page 2 s certificate funeral After t death. Director: / filled in by

requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

Hospital or Attending

hours after within 24 hours a

Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20706 9108 Tallfield Funeral Was Deceu Armed Forces? Yas 2∑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Contracting Officer Federal Government 7yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Equilla Coqdell Sylvester Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9108 Tallfield Ct. Lanham, Mary L. Mason(Wife) Md. Date 20c. Location - City or Town, State 20a. Method of Disposition 2002 Place of Bisposition (Name of on a 1 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Memorial Park 4-13-09 4 Donation 5 Other (Specify) Laurel, Md. WanName Rose of Sacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. Jarry B, Beese MO0483 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm of Brain Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertrophy of Prostate Examiner Due to for se's consequence off Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No Completed 24a. Was an autopsy 2 **X** No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b, Signature and title of bertifier

7. Age (In yrs. last birthday)

66

10c. City, Town or Location

Lanham

Registrar

30. Name and addre

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

s of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1342M Eugene Milton Metz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital *Hagerstown* Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 9, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🕎 M 2 🗆 F 75 Director 218-34-3698 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov ary or other traumatic event, the Medical Examinations to nothing at 1 ☐ Yes 2√ No Directo Maryland Washington Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 11931 Comanche Drive U.S.A.by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Ŷes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Lee Jones Ralph W. Metz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) Mary E. Metz 11931 Comanche Dr. Smithsburg, Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other p. Manor Church of 20a. Method of Disposition April Pate 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Boonsboro , Maryland 2009 Brethren Cemteru 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 toe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONAR **Physician** 0 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed 5 VT pital or Attending Physician: The law requires that the death certificate be executrours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2/No 1 □Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760, Division of Vital Records, P.O.

Certification: To To the Hospital o within 24 hours af To the Funeral DI completely filled in 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

> and address of person who completed cause of death (Item 23a) (Type, Print) Hers m

State Registrar 29b. Signature

and title of certifie

31. Date filed (Month, Day,

SMITWBURG MD

29d. Date signed (Month, Day, Year)

				1 - For State Registrar	St	ate of	Marylan		artment <i>rtificate</i>			Mental Hy	/gien Reg. Ne		JJ	13/34
				Decedent's Name (First, Mi	ddle, Last)					0. 2		2. Date of D	eath			3. Time of Death
		Physici /Medio		Nancy Moss	Poore							April	7, 2	009	Year	2:32 P M
		Examin		4a. Facility Name (If not institu	tion, give street	t and numb	er)				Location of Death			c. County		
				Suburban Hos					Beth					fontgo		<u></u>
	ı	Funeral Director		5. Social Security Number 215–20–6855	6. Sex 1 ☐ M		Age (In yrs. 83	last birthday, Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D March	irth 26, 1	926	9. Birthp	place (State or Foreign offin) yland
		and w		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. Cit	y, Town or L	ocation						1	0d. Inside City Limits
		Maryl f ehc	ļo	D.C.	None			Washi	ngton,	D.0	J.					1⊠Yes 2□No
		1 the	rec	10e. Street and Number					10f. Zip (	Code			10g. C	itizen of W	/hat Cour	ntry?
		th witi	Funeral Director	3904 Yuma St	reet, N	N.W.			2	2001	5			USA		
		ems ems	Iner	11. Marital Status	12. V	Vas Decede	ent Ever in U	.S. 13.	Was Decede	ent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		- Americ	can Indian, etc.
	980	ours afte ral', or it Examin	þ	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ☐ Divor	l If	med Force Yes 2 Yes, Give Year or Date			1 ☐ Yes 2		Specify:			Specify:	7	White
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	121	within ene. then '	Be Completed	Elementary/Secondary (0-1	2) C	ollege (1-4	or 5+)	Nurs		e retired)			Hos	spita.	1 Nu	rse
	9	filed Hygie other	ပိ	17. Father's Name (First, Midd	lle, Last)	-					18. Mother's Nam	e (First, Middl				
	an	hental fental rked ric ev	To B	E. Frank	Moss						Kath	erine P	hill	lips		
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show eny injury or other treumatic event, Ite Medical Examinar must be notified at once.		19a. Informant's Name/Relation		Print)					nd Number or Ru					Code)
	ore,	of Heel of Heel of Item?	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic		val from St	20b. F	Place of Disp emetery, cre				Date		_ocation -		own, State
	Ë	t. Pag tment tant:		4 □ Donation 5 □ Other	(Specify)			tropol			•   -	2009				ia, Va.
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	1	/Medical Examiner		resulting in death)			as a conseq		1		or mitra	.1				Years
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5		uted d ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events	1	Sarco	idosis	5							- 1	Years
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	rds	equire en sig										1 🗆	Yes 2	2 □ No	3 Prob	pabiy 4 ⊠Unknown
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SNAN	Division of Vital Records,	ding h. After funer	Certification:	1X Natural 5 ☐ Per		(Month,	Day Year)	28b. Time of Injury	M	C. Injury Work 1 □ Y	at ? ′es 2∐No	280. Describe	now inji	ury occurre	ad	
X	İSİ	Atten r deal sctor: by the	flca	3 ☐ Suicide 6 ☐ Cou	ld not be	e. Ptace of	Injury - At he	ome, farm, si							er or Rura	I Route Number,
Z	Ş	s after s after of Director	Cert	4 ☐ Homicide		building	, etc. (Specif	y)				City or To	own, Stai	te)		
	5	To the Hospital or Attanding Physicien: The I within 24 hours after death. To the Funarel Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  Check only one)  Certifier  2 Media	al Examiner: (	n: To the bas on the bas and manne	is of examina	wledge, dea tion and/or in	th occurred a rvestigation,	it the timi	e, date and place, inion, death occur	and due to the red at the time	e cause( , date ar	s) and mai nd place, a	nner as si and due to	tated. the cause(s)
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						1-5										

Uti

JAMES

PRENDERGAST,

Registrar

29b. Signature and title of certifier

CATON

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DEYASU A. MEKONEN, M.D

AVE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

32. Registrar's Signature Mersua

29c, License number

D64312

MD 21229

EYASU A. MEKONEU, M.D.

29d. Date signed (Month, Day, Year)

APRIL 15, 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HORU 209 Jacquelyn Payne Chandler Yvonne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Maryland If Under 1 Year | If Under 24 Hrs. 8. D. e George 9. Birthplace (State or Foreign Country) Prince 8. Date of Birth (Month, Day, Year) 12/9/1930 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Months Days Hours Min. 1 □ M 2 🗶 F North 237-48-6123 78 Carolina Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 DXYes 2 □ No Directo Maryland Prince George Fort Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 737 Gleneagles Dr 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ If Yes, Give Year or Dates: 1 ☐Yes 2 🔀 No Specify: Specify: 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George Bd Elementary/Secondary (0-12) College (1-4or 5+) 12 Educator of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Nettie Smith Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah C. Banks/Daughter Gleneagles Dr. Fort Washington MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 4/20/2009 Clinton 21. Signature of Lineral Service Livensee 22. Name and Address of Facility Adams Funeral Home, Aquasco MD 20608 23a. Part 1. Enter the disease, or contolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart deliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMON: A Due to (or as a consequence of): DEPTICEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EMBNIA Exami Due to (or as a consequence of): Physician/Medical MELLITU CABETES IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f shov

other than "natu

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In a mone.

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-06

burial-tran attending physician for use as the buria cate has been signed by the page 2 should be detached funeral director. Be Medical Certification: To After this within 24 hours after death.

To the Funeral Director: by the f

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

24a. Was an autopsy 1 □ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of 2 🗆 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 | Yes 2 | € No 27. Manner of Death

1 Natural

2 Accident

3 🔲 Suicide

29a. Certifier

4 Homicide

5 Pending

28a. Date of Injury (Month, Day, Year) investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

29c. License number MOD58182 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George

APR 15 2009 31. Date filed (Month)

32. Registrar's Signature

7500 Honover Parway Swite 101A Green belt

State Registrar

filled in

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2009 4:35-PM April Proctor Joseph David 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie ANDE Arunde Baltimen washington medical Conter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) 10-30-1936 Maryland 6. Sex 7. Age (In yrs. last birthday) Days 1 **X**M 2 □ F 72 220-34-4031 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □X es 2 □ No Maryland Anne Arundel Glen Bernie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21060 210 Daffodil Rd 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 Nefeb. 57 If Yes, Give Year or Dates Nov. 57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Wivorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Silver Hill Sand Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver and Gravel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ρ. Proctor Elizabeth William H. Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Daffodil Rd, Glen Bernie MD 21060 David Proctor / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2009 Cheltenham MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 22. Name and Address of Facility 21. Signature of Juneral Service Licenses Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a msequence of): Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery Day Month Year use contribute to the cause of death? Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

Examiner

Physician/Medical

<u>6</u>

Completed

Be

Certification: To

Medical

3 Suicide

4 Homicide

**Physician** 

/Medical

**Examiner** 

10a. State

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Directo

Funeral

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Completed

Be

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examina ones.

with the Maryland

death

Maryland 21215-0036

Baltimore,

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the Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans cate has been signed by the attending physician page 2 should be detached for use as the burial

certificate funeral director, After this ours after death.

neral Director: A

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 🗆 Ectopic pre		
	ns contributing to death but not resultin		se given in Part I.	23e. Did tobacco
	destructive of		lesson	24a. Was an autopsy performed? 1 □ Yes 24⊒N
25. Was case referred to medical			26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 <del>☐ No</del>	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 ☐ DOA	Other: 4 Nursing H	lome 5 ☐ Residence
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day, Year)	b. Time of lnjury M	c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how inju

28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)

26. Place of Dea	th (Check only one)
Other: 4 \( \text{Nursing H} \)	ome 5 ☐ Residence 6 ☐ Other (Specify)
Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury occurred
ice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 Certifying Phys	ician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to th	ne cause(s) and manner as stated.
(Check only one)	2☐ Medical Examin	er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time	e, date and place, and due to the cause(
29h Signature and	title of certifier		29c. License number		29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

100 D0014147 April 8 2009

ted clause of death (Item 23a) (Type, Print)

305 Hospital Dr Seite 305 Glen Burnie MD 2016/

State

William 31. Date filed (Month, Day, Year) APR 15 2009

32. Registrar's Signature

Registrar

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 09:18 AM **EDNA** LOUISE PRYOR 2009 Hpml 22 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 11 7. Age (In yrs. last birthday) · 1919 Maryland Days 1 □ M 2 😾 F 218-62-9039 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☑ No Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8507 Mapleville Road 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wade Grossnickle Maudie Be11 Blickenstaff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Pryor/son 13500 Loy Wolfe Road, Smithsburg, Maryland 21783 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grossnickle Brethren Apr. 25, 2009 Myersville, Maryland 4 Donation 5 Other (Specify) Signature of Eugeral Service Lice 504 Main Street 22. Name and Address of Facility

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

Be Completed by Physician/Medical Examiner

Medical Certification: To

FAR 10

31. Date filed (Month, Day, Year)

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ingr must be notified at

Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Evantangones.

Baltimore, Maryland 21215-0036

21. Signature of Pullerar Service Licent		Ricketts Funeral Home Myersville, MD 21773								
JAK CTULL				1110, 11						
23a. Part 1 Enter the disease, or comp shock of heart failure. List only	olications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition	a Mycard	ial Infarct	10h		Onset and Death					
	Due to (or as a consequence of):			-						
shool of heart failure. List only one cause on each line.  Immediate Cause (Final issease or condition esulting in death)  Bequentially list conditions, any, leading to immediate ausse. Enter Underlying ausse (Dieases or rijury esulting in death)  Bue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of										
that initiated events resulting in death) Last	C. Due to (or as a consequence of):									
in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death				livery Day Year					
Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.								
			autopsy performed?	prior to death?	utopsy findings available completion of cause of					
25. Was case referred to medical			th (Check only one)							
	Hospital: 1 Inpatient 2 ER/Outpa	tient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 Residence	6 ☐ Other (Spe	ecify)					
2 ☐ Accident investigation	(Month, Day, Year) Injur	y Work?	28d. Describe how inj	ury occurred						
determined	28e. Place of injury - At nome, farm,	street, factory, office			ural Route Number,					
(Check only 2 Medicel Exen	niner: On the basis of examination and/o									
29b. Signature and title of certifier   Turing	meland			5 '						
30 Name and address of person who	completed cause of death (Item 23a) (Tvi	ne Print)		1_						

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	-		ificate of			Reg. No.	2009	13799
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De Month			3. Time of Death
-	/Medic	al	4a. Facility Name (If not institution, giv		den		4h City Town o	r Location of Death	64	18	2009 County of Deat	
المرس	Examin	er	636 Gravelly	Run R	Ed.		10 . 6 . 1 .	enry			30550	. 1
	Funeral Director		215-32-7000	ex 7. Age	(In yrs. last birt	hday) rs.	If Under 1 Year Months Days	If Under \$4 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/4/1	th ly, Year) 935	Co	thplace (State or Foreign puntry) ryland
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Limits
	e Mary 3a-fsh	Director	MD Gar:	cett	McH	Ienr	У					1 □Yes 2⁄⁄∏No
	a or 24	Dire	10e. Street and Number				10f. Zip Code	4.1			en of What Co	•
	death	nera	36 Gravelly Ru 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E	ver in U.S.	13. W	215	년 1 lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		4. Race - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaring ruel be natified at once.	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	0		Yes 2∭ No		o Filican, etc.)		Black, White Specify: Wh	e, etc. nite
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O. Box	death e atten d for u	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnanc Other <i>(specify)</i> _	У		2	3d. Date of de Month	Day Year
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	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical (	29a. Certifier (Check only one)  1 CertifyIng Ph	yslcien: To the best on niner: On the basis of and manner sta	examination and	, death o	occurred at the til stigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:55PM 2009 Joy Elaine Reese 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2 D/F 60 216-54-8096 Nov. 18, 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 √ Yes 2 □ No Maryland Washington Keedysville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 25 Antietam Drive 21756 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvin E. Reese Othelia E. Ridenour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly E. Midgley (Daughter) 16233 Eylers Valley Rd. Thurmont, Maryland 21788 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 ☐Other (Specify) 2009 Signature of Funeral Service 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the co Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as onsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): FEMALE: b. Was decedent pregnant in the past 12 months? If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) a∏Unknown 9 Unknown t II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

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Items 23a

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7 is marked other traumatic event.

Health and Mental eq pinous

permit, Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.

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72 hours after

Baltimore, Maryland 21215-0036

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Director

Funeral

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Division of Vital

/Medical Examiner sign Be s certificate has irector, page 2 s director, After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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tion: T	27.

IF FEMALE: Was case referred to medical examiner? 1 ☐ Yes _ 2 ☐ K Mann of Death 1 Watural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a, Certifier

(Check only one)

29b. Signature and title of cer

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Certification		

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Registrar

1 □ Yes 2 🖬 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number D0047115 MO.

29d. Date signed (Month, Day, Year)

medicaL CAmpus Rd #228

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (evin 11110

Hospital:

5 Pending

investigation

6 Could not be determined

Ket

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2009 Month **Physician** 5:10 P April 10, Sackor Morris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Ma Worth, Pay, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 № M 2 🗆 F 220-53-0317 44 Liberia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23.5.7.7. any injury or other traumatic event. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 Yes 2 No Silver Spring Director Montgomery Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20904 3005 Shepperton Terr. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 1 No Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Makura Kamara Sekou Sackor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Shepparton Terr. Silver Spring, Md. 20904 Hawa Sackor/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 12'09Laurel, Maryland Maryland National 4 ☐ Donation 5 ☐ Other (Specify) 3831 Georgia Avenue, N.W. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD# 278 Latney's Funeral Home Washington, D. C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acquired Immunodeficiency Syndrome Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) o ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐Yes 2 ☐ No 1 □Yes 2 **X** No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \boxtimes$  Other (Specify)  $\underbrace{\text{Hospice}}$ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Il Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 2 00063748 Jocel April 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 6001- Muncaster Mill Road Rockville, MD 20855 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

09-02961 Paul Schmitt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ul Schmitt		- For State	State	of Marylan		tment of		and Mente	ai i iygic		No	200	9 1:	3802
	F	Registrar  1. Decedent's Name	(First Middle Le		Certi	ilicate of	Death			Reg. ate of Death			. Time of Death	1
Physicia edical Exami	A I 6.			31)					Ar Ar	onth D oril 14, 200	ay ` 19	/ear	0614 hrs	
CICAI EXAIIII		Paul S  4a. Facility Name (if		ve street and num	ber)	4	b. City, Towr	n, or Location of	Death			ty of Death		
		Howard Cour					Columbi	ia			Howa			
Funeral		5. Social Security Nu	ımber 6. S	Sex 7	. Age (In yrs. las	st birthday)	If Under 1			Date of Birth (	MM/DD/YY	Foreign	olace (State or	
Director				M 2 F	4.5	Yrs.	Months	Days Hours	Min.	06/22/3	1963	Coun	try) MD	
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he Ma n or 2 iffed	i i	7800 Flag	rstone C	ourt				21043				State		
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f sho ther Medical Examiner must be notified at once.	Funeral Dir	11. Marital Status		12. Was Dece	dent Ever in U.S	3. 13. Wa	s Decedent	of Hispanic Origi Cuban, Mexican,	in? ( Specify Puerto Rica	y Yes or No- an, etc.)		tace - America Vhite, etc.	an Indian, Blac	к,
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15-003 Hed within Hygiene.	Completed	17, Father's Name (	(First Middle La	5+		Busii	ness M	lanager 18.Mother	's Name (Fi	rst, Middle, M				
15-6 Fled Hyg	ပြ	John C.						Dolo	res V	otta				
21215-0036 uld be filed within 7 Mental Hygiene. marker other than	To Be	19a. Informant's Na						(Street and Num						
nore, MD 21215-0036 ages I and 2 should be I lot within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", or items 23a or 28a-f show any uter transmatic event, the Medical Examiner must be notified at once.	١٦	Linda Kr				7800 1	Flagst	one Cou	rt El	licott	City	MD 21 tion - City or	.043	
e, N and Health item		20a. Method of Disp	position			Place of Dispor		of cemetery,		ate	20c. Loca	tion - Gity or	Town, State	ļ
DOF ages l nt of l t: If		1X Burial 2		3 Removal fro	om State	. John		netery	04/1	8/09	Elli	.cott C	ity, M	
Baltimore, serm.t. Pages I at Department of Hes Important: If ite injury or other tringury or other tr		4 Donation 5 21 Signature of Fu	Other Specineral Service Li	censeen	4			ddress of Facility Columb	y Harr	v H. W	itzke	's Fam	uly F.	H. Inc
Battimore, MD 21215 perm.t. Pages I and 2 should be file Deperment of Health and Mental Hi. Important: If item 27 is marked to injury or other transmatic event, Man	1	Shew (	ollows -	Withily	MOLO	44 41:	12 Old	Columb	ia Pi	ke Ell	icott	City	MD 210	43
Physiciar	_	23a. Part I. Enter the	ne disease, or co	each line	aused the death	. Do not enter	the mode of	dying, such as o	cardiac of re	spiratory arre	St, SHOCK,	or rieart	Between Or	nset and
'Medica		Immediate Cause (	-	a. Multiple Inj	uries									
tamine		or condition resulti	ng in death)	Due to (or as a	consequence	of):								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	<u> </u>	<u> </u>		d										
ox 68760, eath certificate be execut attending physician and for use as the physical - tran	ledical	UNPENDED		AMENDED						_	23d. D	ate of deliver	у	
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certi	sician/M	past 12 month			nant at time of d	eath 5	Other (Spec	cify)						- 1
Box e death c the atten		1 Yes 2		9 Oliki				esupe siyon in F	Port I	23e. Did to	obacco use	e contribute to	the cause of	death?
P.O. s that the gned by	D P		nificant condition	ons contributing	to death but not	resulting in the	e underlying	cause given in i	aiti.				bably 4 🔲 t	
F. P.C ires that isigned to		M								24a. Was	an	24b. Were a	utopsy findings	available
ords, w requir	page 2 should be									autop	osy ormed?	prior to death?	completion of	cause of
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tal Rec sian: The certificate			erred to medical					26.Place of Deat			Desidos	e 6 Oth		
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of ing Ph	funeral	. 27. Manner of De.		28a. Dat	e of Injury th, Day Year) , 2009	28b. Time o	of Injury	28c. Injury at Wo		Driver auto				:
ion tendii	the fr	1 Natural 2 Accident	5 Pend Inves	ing						20f Location	(Street and	Number or F	Rural Route Nu	mber, City
Division of Vital Records, ral or Attending Physician: The law requir us after death.	in by	3 Sulcide		not be			treet, factory	, office building,		as Tours	Ctata)	ad, Ellicott (		- 1
pital Di	filled in by the fune	4 Homicide			/) Local Str			- V data and						
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:			Certifying Ph	ysician: To the b	est of my knowle s of examination	edge, death oc n and/or investi	curred at the igation, in my	e time, date and y opinion, death	occurred at	the time, date	e and place	e, and due to	the cause(s)	
To the To the	completely	K		and manne	stated.			c. License numb			29d. Da	ate signed (N	Month, Day, Yea	ir)
	2	29b. Signature ar	no title of certifie				-5	O.C.M.E.			April	15, 2009		
		and			<del> </del>	20-1								
(10)02				who completed ca	iuse of death (It I Examiner	em 23a) 111 Peni	n Street.	Baltimore, M	ID 21201					
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			101	te of Death	Reg. I		
1. 18	Physici /Medic		1. Decedent's Name (First, Middle, Last) Wilbert Smith		Date of Death Month	Day Year 9 09	3. Time of Death 0755 M
je je	Examir			, Town, or Location of Death		4c. County of Dea	
			Deer's Head Hospital Center So 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	uisbury or 1 Year I If Under 24 Hrs. 8	Date of Birth	Wicor	
*	Funeral Director		216-18-5299 1 1 1 2 F 85 Yrs. Months Usual Residence of Decedent	Days Hours Min.	(Month, Day, Yea	1923 Ma	thplace (State or Foreign buntry) ryland
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow Iteal Exarterat must be challified at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Maryland 28a-f show	Director	Maryland Anne Arundel Crownsvil	le			1 □ Yes 2 No
	with th			ip Code	10g. (	Citizen of What Co	ountry?
	eath v	Funeral	738 Old Herald Harbor Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	21032	Ves or No.	USA 14. Race - Ame	nican Indian
"	after d or item	Fun	1 Never Married 2 Married 1 Yes 2 No	edent of Hispanic Origin? (Specify ecify Cuban, Mexican, Puerto Rica 	an, etc.)	Black, White	
03	hours a tural', o	þ	If Yes, Give ↑  3 ☐ Widowed 4 ☐ Divorced   If Yes, Give ↑  Year or Dates: 1 ☐ Yes	2  ▼ No Specify:		Specify: B	lack
5-0	72 h	etec	15. Decedent's Education 16a. Decedent's Usi (Specify only highest grade completed) (Give kind of w	ork done during most of working	16b.	Kind of Business	/Industry
121	d within piene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			T7 1	
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Baltimore,	a 0 - =		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nacemetery, crematory or	other place)		Location - City or	
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Ba	permit. Departimport Import eny inj			West St. Anna			
	, sig		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.				Approximate Interval Between
100	Physician		1 1 1 1 1 1	ovascular disec	0).		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	11 +			10
в	LAdminer	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	cident			
	and -transit	caminer	cause. Enter Underlying Cause (Disease or injury				
ď.	executed in and ial-transi	Exai	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):	***************************************			
68760,	certificate be ex iding physician ise as the burial	cal	d				
99 )	artifica ing ph	Med	IF FEMALE:				
Box	death cert e attendin ed for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic past 12 months?			23d. Date of de Month	ivery Day Year
0	that the de ed by the a detached t	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Preg <i>n</i> ant at time of death 5 ☐ Other (s 9 ☐ Unknown 9 ☐ Unknown	pecify)			,
4	requires that the een signed by the rould be detache		Part II. Dther significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w requires been sign should be	ed by			1 🔀 Yes	2 □ No 3 □ Pi	obably 4 Dunknown
Vital Records,	aw 1s b	Completed	Dementia	-	24a. Was an autopsy	24b. Were at	itopsy findings available
Ä	The ate h page	Com			performed?	? death?	completion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (C.	heck only one)		
	this al dii	٦.	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D  27. Manner of Death 28a. Date of Injury 28b. Time of				cify)
on	Jing After fune	tlon	27. Manner of Death 1 28 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)  M  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	. Describe how in	ijury occurred	
Division of	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor				ural Route Number,
Ö	s afte	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ate)	
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	cal	29a. Certifier (Chack only one)  1 Certifying Physician: To the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge, death occurred to the best of my knowledge.	n in my aninion, death accurred a	t the time date a	and place and due	to the causals)
	vithin o the	Mec	29b. Signature and title of certifier / 25	c. License number	29d. [	Date signed (Mont	h, Day, Year)
		)	In Deline	40066064	04	1/09/200	9
,	9 Ber		and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TONY SONSALVES, Deep's Head Hospital  31. Date filed (Month, Day, Year)  APR 14 2009  32. Pegistrar's Signature  APR 14 2009	1 Couter 351 Dee	r's Head	Hospital	read, Satisbury
74% 3 5 di	Sta Registr	te ar	31. Date filed (Month, Day, Year)  ADD 14 2009  32. Registrar's Signature	,		J	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR 14

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4:00 P M 2009 4c. County of Death N/A 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 17 Yes 2 □ No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Rookie's <u>Meat Market</u> Annapolis, Md. 21403 20c. Location - City or Town, State Annapolis, Md. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖫 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) AVE BALTIMORE

Registrar

After

the Funeral Director: Aft

To the

Medical

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

El

31. Date filed (Month, Day, Year) APR 14 2009

investigation

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANG M.D.

6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

101 STHELENA

1 ☐ Yes 2 ☐ No

29c. License number

17202

Certificate of Death

13806

Reg. No. 2009

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar

n al								Mon	ith I	Day Year	r		
	Alan	LeRoy	Verbin					1	1 11,	2009	7:14 P. M		
er	4a. Facility Name (/	f not institution,	give street and nu	mber)		4b. City, Town, or	Location of	of Death		4c. County of De			
	Anne Aru					Annapoli				Anne Aru			
	5. Social Security N  161-28-3  Usual Residence of	329	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. 73	last birthday, Yrs.	Months Days	If Under Hours	Min. (Moi	of Birth oth, Day, Yes 24,		irthplace (State or Foreigi Country) nnsylvania		
	10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits		
by Funeral Director	Maryland		Arundel		cofton						1. Yes 2 □ No		
	10e. Street and Nur 1481 Harv		e.			10f. Zip Code 21114	4			Citizen of What C	Country?		
		11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	ispanic Ori in, Mexicar Specify:		or No- tc.)	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc. White		
eted	(Spec	15. Decedent's	s Education t grade completed)	-	16a. Dece	edent's Usual Occup	ation during mos	t of working	16b	. Kind of Busines	s/Industry		
Be Completed	Elementary/Seco		I-4or 5+)	life.	DO NOT use retired space Engi	erospace							
lo Be (	17. Father's Name							er's Name <i>(First, I</i> sie Gold		den Surname)			
	19a. Informant's Na Janet F.					ng Address <i>(Street d</i> 1 Harwe11				-	, Zip Code) 21114		
	20a. Method of Disp		3 ☐ Removal from	20b. F	Place of Disponentery, cre	osition (Name of matory or other place	e)	Date	20c.	. Location - City o	or Town, State		
	4 ☐ Donation	5 ☐ Other (Sp	ecify)	State			- 1	4/15/200	9   Wa	aldorf,	Maryland		
	21. Signature of Fu	4 Donation 5 Other (Specify) Huntt Crematory 4/15/2009 Waldorf, Maryland  1. Signature of Fund and Address of Facility Robert E. Evans Funeral Home,  16000 Annapolis Road, Bowie, Maryland 20715											
	resulting in death)  Due to (or as a conse uence of):  Sequentially list conditions, if any, leading to immediate cruss that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.										years		
icai Examiner	that initiated events	injury	b	or as a conseq	uence of): uence of):	le le					91443		
cian/medical	that initiated events	ast t pregnant months?	b	(or as a conseq (or as a conseq come of pregni birth 2 □ Feta nant at time of c	uence of):  uence of):  uence of):  ancy  il death 3	□ Ectopic pregnance	у			23d. Date of d Month			
by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1	ast  t pregnant months?	b	(or as a consequence of pregnation of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of	uence of):  uence of):  uence of):  ancy al death 3 l death 5 l	□ Ectopic pregnanc: □ Other (specify) _		. 23e	10	Month co use contribute	lelivery Day Year to the cause of death?		
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To be completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1	t pregnant months?	b	(or as a consequence of pregnation to the come of pregnation to the come of pregnation to the come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of come of	uence of):  uence of):  uence of):  ancy al death 3 l death 5 l  ulting in the u	☐ Ectopic pregnance ☐ Other (specify) ☐ Inderlying cause give	en in Part I.  26. Place	24a 1 □ e of Death (Check ursing Home 5 □	Was an autopsy performed Yes 2 only one)  Residence	Month  co use contribute  2 No 3 Prior to death? No 1 Ye	lelivery Day Year  to the cause of death?  Probably 4 □ Unknown autopsy findings available o completion of cause of		
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Be Completed by Physician/Intedical	IF FEMALE: 23b. Was decedent in the past 12 1	t pregnant months?  No  red to medical  No  h 5  Pending investiga 6  Could no determin	b	(or as a consequence of pregnation of pregnation of pregnation of pregnation of cown eath but not result of Injury th, Day, Year)  of Injury - At hing, etc. (Special	uence of):  uence of):  uence of):  uence of):  ancy al death 3 l death 5 l ulting in the u  UER/Outpatie  28b. Time of Injury  ome, farm, str	□ Ectopic pregnance □ Other (specify) □ Inderlying cause give  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other  Int 3 □ DOA Other	26. Place ar: 4 \( \) Nu y at ? Yes 2 \( \)	24a  1 □ e of Death (Check ursing Home 5 □ 28d. Des No 28f. Loca City	Was an autopsy performed Yes 25 only one)  Residence cribe how in aution (Street or Town, St.	Month  20 use contribute  2 No 3 S  24b. Were a prior to death? No 1 Ye  6 Other (Sp. njury occurred  and Number or fate)	lelivery Day Year  to the cause of death? Probably 4 Unknown autopsy findings available o completion of cause of es 2 No  pecify)  Rural Route Number, as stated.		

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 19:45 PM Nac 00 arwin 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland 6. Sex University of 5. Social Security Number Medical Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Days Hours Min. Director 28, 1939 70 Pennsylvania <u> 162–32–5017</u> Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f sho event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 USA 500 Riverside Drive #117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 1 1963 -If Yes, Give 1984 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer U.S. Army 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Violet Darlington Darwin Morton Way, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 500 Riverside Dr #117, Pocomoke City, MD 21851 George Ann Way (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 7/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Furieral Service Licens 22. Name and Address of Facility. Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of t Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Division of Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 1 □Yes 2 2 No 1 🗆 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA20+1 Baltimore timee 93 Greene

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State

Registrar

31. Date filed (Month, Day, Year)

15

32. Registrar's Signature

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 □ No

Maryland Maryland

14. Race - American Indian,

White

Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

4 🗹 Unknown

Month

20/09

21550

Specify:

3:55 A M

Year

2009

1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Katherine I. Wilt 19 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oakland Nursing & Rehab Center Garrett 0akland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Director 212-38-6011 81 April 19 1928 Usual Residence of Decedent 10c, City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedical Examination restriction at Director MD Garrett Kitzmiller 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1207 Homestead St. 21538 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker/Farmer Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev ٥ George Wilt Viola Laura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjana Greaser, Friend 4711 Kitzmiller Rd., Kitzmiller, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Hamill Cemetery Kitzmiller, MD 22. Name and Address of Facility David A. Burdock Funeral Home, 710 Church St., Kitzmiller, MD 21. Signature of Funeral Service Licensee Katherine Sweetse 23a. Part 1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has b page 2 st 24a. Was an autonsy this certificate 1 ☐ Yes 2₽No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson,

32. Registrar's Signature

Thomas G.

311 N. 4th Street, Oakland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 13809 State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4/17/2009 THEODORE WILLIAM WILHELM 2:50 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home Oakland Garrett If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/8/1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 3M 2 F Director 233-42-9621 80 WV Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Marylend nent of Heetih and Mental Hyglene. ant: if Item 27 ie marked other then "naturel", or Items 23s or 28s-f ehow ary or other traumatic event, if a Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits WV 1 ☐ Yes 2 ☑ No Preston Directo Terra Alta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RR 2 Box 160C 26764 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - Americen Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married altimore. Maryland 21215-0036 1 ☐ Yes X☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Board of Education 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Roosevelt Wilhelm ဥ Mary Melvina Trainer Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wilhelm/Spouse RR 2 Box 160C, Terra Alta, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c Location - City or Town State permit. Peges to Depertment of Himportant: If Italian any Injury or ot 2005. 1 Daurial 2 Cremation 3 Removal from State Cranesville Cemetery 4/20/2009 Terra Alta, WV * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 26764 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Progressive ischemic YEARS /Medical Due to ar as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed riabetes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificete has b lirector, pege 2 s autopsy performed? res 25 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) ၉ the funerel dir this 27. Manner of Death Natural Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation er death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fun completely 1 and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar m.D.

32. Registrar's Signature

6. Johnson

1 homes

31. Date filed (Month, Day, Year)

Fourth St., Oakland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Year **Physician** 3:28AM 2009 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARUNDE ( MEDICAL CENTER BURNJE ANNE BACTIMORE WASHINGTON 8. Date of Birth (Month, Day, Year 7 - 9 - 1 9 7 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2**X** F 37 MD Director 215-96-9797 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Modical Examinar must be notified Director 1 X Yes 2 □ No MD Garrett Deer Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21550 USA 101 Peach Tree Lane by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Men'a Important: If Item 27 Is marked i any Injury or other traumatic ev Joyce F. Duckworth Jerry D. Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norman L. Wilhelm, Husband 101 Peach Tree Lane Deer Park, MD 21550 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-15-09 Parnell Cemeterv Cuzzard, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Solvice Licensee 22. Name and Address of Facility Fredlock Funeral Home 31 Jones St. Do not enter the mode of dying, such as cardiac or fespiratory arrest. 23a. Part 1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO RES /Medical Due to (or as a consequence of): Examiner SEPS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No ed by the 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 2 No 3 Probably Completed 24b. Were eutopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ₽ No 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A

bletely filled in by the fu 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated within 2.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

32. Registrar's Signature

Washing ton

D 0063564

29d. Date signed (Month, Day, Year)

Medical Center, 301 May tal Drive, Glen Burne

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan				/lental Hyg	iene				
			Registrar		Ce	rtificate of l	Death	r	eg. No.2	9	13811		
	Physic	ian	1. Decedent's Name <i>(First, Middle, L</i> Dorothy	ast) Williams				2. Date of Deat Month	Day Y	ear	3. Time of Death		
	/Medi							April 1	1, 2009		11:00Pм		
	Exami	ner	4a. Facility Name (If not institution, g Crescent Citi	,			Location of Death		4c. County of Death				
	Funeral			Sex 7. Age (In yrs.	last birthdav)	Riverda		8. Date of Birth	Prince George's  9. Birthplace (State or Foreign				
	Director		380-34-4493	^{1□ M 2} X 70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 7	,1938	Count	de Island		
	pu ,		Usual Residence of Decedent			<u></u>		, seper ,	,1,00				
	r 28a-f show	5	10a. State 10b. County		y, Town or Lo	cation				10	Od. Inside City Limits		
	he M	Director	Maryland Prince  10e. Street and Number	George's	J	Jpper Marl	lboro				1 ☐ Yes 2 📉 No		
	ath with 1					10f. Zip Code		1	0g. Citizen of Wha		try?		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show filed Exardi at must be notified at	Funeral	11002 Hallow W	ay 12. Was Decedent Ever in U.	S. 13.	20772		ecify Ves or No-	U.S 14. Race -	.A.	an Indian		
9	after c		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 □ No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, \	White, e	tc.		
21215-0036	ral", c	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1 □Yes 2 <b>X</b> XNo	Specify:		Specify:				
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121	ithir ne. <b>han</b>	큩	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	)	"'g	**		_		
2	e filed wal Hygie other t	ပိ	17. Father's Name (First, Middle, Las		Las	hier	40.14-15-15-15-	(Fi - 1 44 4 4 4 - 1	Hospi	tali	ity		
anc	be f ental l	Be c	Paul Logan	si)			18. Mother's Name		urner				
Maryland	should nd Me mark mati	욘	19a. Informant's Name/Relationship	(Type Print)	19h Mailir	ng Address (Street a				ato Zin	Cada		
	nd 2 alth a alth a 27 is		Claude Williams	(Husband)	1	2 Hallow							
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other tt any injury or other traumatic event, In once.		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date 2	20c. Location - Cit				
Ē	Page nent unt: If		1 ☐ Burial 2 <b>X</b> Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	_ Hemoval nom state	e Crem		″ ¦ Apri. 2009	1 13,	Clinton	Ms	arvland		
alt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice			2. Name and Addres			Home, 6	6633	Old		
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-	/Medical Examiner		resulting in death)	Due to (or as a consequ							G ZZ I		
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68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	edical		⊾ d.									
68	rtifica ng ph as th	fedi											
Box	death certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date o	f deliver	ту		
O. E	e dea he at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of d		Other (specify)			Month	Γ	Day Year		
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Rec	has has ge 2 s	id m	Travers	viellity.	S			24a. Was an autopsy	/ prio	r to com	sy findings available pletion of cause of		
a	n: Th ficate r, pag		Arteriosa	erote Car	diol	iascular	- Discas	perform 1 □ Yes 2	ned? dea □No 1 □	in?  Yes 2	2 □ No		
Ξ	sicia certi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Othe	26. Place of Death						
of	ding Physician: The In. After this certificate ha funeral director, page	. To	27. Manner of Death	1   Inpatient 2   I	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 Lativursing Hol	me 5 Resider	nce 6 Other	Specify)	)		
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Division	al or Attendin s after death. I Director: Af ed in by the fur	ij	3 Suicide 6 Could not to determined		me, farm, stre	eet, factory, office		28f. Location (Str	eet and Number o	or Rural	Route Number,		
	tal or rs afte al Dir ed in	Certification:	4 🗆 Hornicide	building, etc. (Specify	"			City or Town,	, State)				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune		Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat	wledge, death	occurred at the tim	e, date and place,	and due to the ca	ause(s) and mann	er as sta	ated.		
	the h	Medical		and manner stated.									
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		+	20. Nome and address	we me	00-1/7	DOL	87 x		APRIL 1				
(	BID		30. Name and address of person who	Completed cause of death (Item	*	veensk	rux Da	Huatt	Sville	MA	20781		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		harked	or you	. 19001			/ - /		
	Registr	ar	APR 15	2009 Deneur	p. 4	Waste							

Registrar
DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3812 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 George O. Washington 2009 April 8:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 329 Dubois Road Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months XXM 2 F 213-16-0704 86 28, 1923 Feb. North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Dubois Road 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: ₩W II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

Carpentry

21401

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Beck

IDENTIER Edoug DR, Annagaler, 170 2'41/

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1872 Severn Grove Road Annapolis, Maryland

**Physician** /Medical Examiner

> burial-tra physician the burial

been signe should be c

certificate has irector, page 2 s

funeral

within 24 hours after death

To the Funeral Director:
completely filled in by the f

1 - For State Registrar

**Physician** 

/Medical

Director

Funeral

ş

Completed

Be

ပ

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Clarence M. Washington

19a. Informant's Name/Relationship (Type. Print)

Deborah Cream/daughter

6

College (1-4or 5+)

Examiner

**Funeral** 

Director

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Model Examiner must be notified at

Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, It once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition		20b. Place of Dispersion	osition (Name of matory or other place	) !	Date	20c. Location - City of	Town, State
	1 ☐ Burial <b>②CX</b> Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	,	oln Cremat	, ,	5/2009	Brentwood,	Maryland
1	21. Signatur Fineral Service Licensee	11	7 2	2. Name and Address	of Facility Jo	hn M. Ta	ylor Funera	al Home
	Jodo E	Rill						s, MD 21401
	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused th	e death. Do not en	ter the mode of dying	, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Chron	ma Oll	Structi	100 -10	Ma I	165465	Onset and Death
	resulting in death)	Due to (or as a c		2 I INC (1		may p	1761170	10 402
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8	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a o	Oliseque.iCe Ol).					
	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
	resulting in death) Last	Due to (or as a c	consequence of):					
	d							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	i. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions contri	buting to death but r	not resulting in the u	inderlying cause giver	in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
	5 marsage					113	<b>/</b> es 2 ☐ No 3 ☐ F	robably 4 ☐ Unknow
1						24a. Was		utopsy findings available
						autop perfo 1 ∐Yes	rmed? death?	completion of cause of s 2 □No
	25. Was case referred to medical examiner?					ath (Check only o	ne)	
,	1 1es 2 2 30 10		2 ☐ ER/Outpatie		4 LI Nursing H	lome 5 Resid	dence 6 ☐ Other (Spe	ecify)
	27. Manner of De th  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) 28b. Time of Injury	Work?	at es 2 <mark>□No</mark>	28d. Describe h	now injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or Fi vn, State)	ural Route Number,
	29a. Certifier (Check only one)  1	ian: To the best of r r: On the basis of ex and manner stated	kamination and/or ir	th occurred at the time envestigation, in my op	e, date and place nion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mon	th, Day, Year)
1	In B So	use of	7	000	18529	-HD	04-13-	2609

DHMH 17 Rev 1/2001

State

Registrar

Jon

APR 14 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State o	f Marylar	nd / Depa	artment of H	lealth and N		and the sale		10010
		State Registrar			Ce	rtificate of l	Death	R	eg. No. 2 (	009	13813
Physici	an	Decedent's Name (First, Middle	,,	-		Vour	. ~	2. Date of Deat Month	Day	Year	3. Time of Death
/Medio		Joseph  4a. Facility Name (If not institution		mber)		Your	Location of Death	4-12		ty of Death	01:12 M
Examin	er	Southern Mar		,	1	Clinto					eorge
Funeral			6. Sex 1 → M 2 □ F	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	lace (State or Foreign
Director		579-82-7514	1CFM 2LIF	47	Yrs.			1 - 17 -	1962	Mary	yland
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
Mary a-f sh	ģ	Maryland Prin	ce Geor	ge F	ort W	ashingto	วท				1 ☐ Wes 2 ☐ No
th the	Director	10e. Street and Number	0001	90   1	OI C II	10f. Zip Code		1	0g. Citizen of	What Cour	itry?
ath wi	ral	6521 Bucklan				207			USA		
er des items	Funeral	11. Marital Status 1 ☐ Never Married 2 Marri	Armed Fo	edent Ever in U	l.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, (	
ours aft	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		1 □ Yes 2 □ <b>X</b> lo	Specify:		Speci	ify: Bla	ck
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To the Hospital or Attending Physician: within 24 hours after death, as a fire death or To the Funeral Director; After this certifica completely filled in by the funeral director, it	edical		examiner: On the b								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 10-22 PM 2009 JAHES ALLEN AFFEZL 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHNS HUPKINS BAYVIEW HEISTEAL CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | October 1, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 217**-3**4-5074 72 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Experiment must be mutilled at 1 Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21224 3827 Foster Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after ( Health and Mental Hygiene. em 27 is marked other than "natural", or Itel 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify Specify: White ۾ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) General Motors Firancial Analysis 12 years 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Edler Henry L. Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Marylouise Aller 3827 Foster Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 2,2009 Baltimore: Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connectly Funeral Home of Durdalk, P. A. 7/10 Sollers Point Road, Durdalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner & DAYS LOWER EXTREMITY CELLY LITTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PROSTATE CANCER CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 nnea 2 MNo 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide ō 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 3 0 2

TU

BENJAMIN

4940 EASTERN AVENUE 32. Registrar's Sign (ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND

29c. License number

RES -OOC

BALTIMORE, MA

29d. Date signed (Month, Day, Year)

28, 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Registrar	Item ^{State o}	f Maryland r fn, g891	, 859	artment of H 11/09dhb rtificate of t	ealth a D <i>eath</i>	and Mental H	ygiene Reg. No.	09	13815	
H	Physici	an	1. Decedent's Name (First, Middle Ru-Bost		HORMS				2. Date of D Month	Day	Year 2009	3. Time of Death	
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I	Funeral Director		5 Social Security Number 215-32-3800	6. Sex 1	7. Age (In yrs. last 72	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. Date of B (Month, Dec 23	irth Pay, Year) 1936	Cou	place (State or Foreign ntry) yland	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation					10d. fnside City Limits	
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Z Z	V 00 = 4		19a. Informant's Name/Relations Francine Adams				ng Address <i>(Street a</i> 527 Berli		er or Rural Route Num  21811	ber, City or Town	i, State, Zip	Code)	
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State of Maryland / Department of Health and Mental Hygiene

2009 13816

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	6923 Ridgev		. Age (In yrs. last birthday)	Dundalk  If Under 1 Year	If Under 24Hr	s. 8. Date of Birth (N	Baltimore Cou	
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any	Usual Residence of 10a. State	Decedent 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
<b>à</b> .	Maryland	Baltimore	De	undalk				1 Yes 2 X No
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ith the notific		Battle Grove Roc	dent Ever in U.S. 13.	2122 Was Decedent of His	panic Origin? ( §	Specify Yes or No-	14. Race - Ame	ican Indian, Black,
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P.O. es that the signed by be detach		nificant conditions contributing to disease; Diabete		the underlying cause	given in Part I.			robably 4 🗸 Unknowr
cords, P.O. B law requires that the d has been signed by the should be detached		uisease, biasece	merricus.			24a. Was ar autops		autopsy findings availat o completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed					perform	ned? death	?
ital Recion: The Scertificate rector, page		erred to medical		26.Pla	ce of Death (Che			
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n of ding Ph	27. Manner of De	ath 28a. Date (Month	of Injury 285. Him	· · ·	Yes 2 No	200. 50001150 11	on injury coourses	
isio	2 Accident	Investigation	e of injury - At home, farm	, street, factory, office	building, etc.	28f. Location (St or Town, St		Rural Route Number, Ci
Div Div ours after in Illed in	27. Mainter of De 1 X Natural 2 Accident 3 Suicide 4 Homicide	determined (Specify)						
		Certifying Physician: To the bes  Medical Examiner: On the basis	st of my knowledge, death of examination and/or inve	occurred at the time, estigation, in my opini	date and place, on, death occurr	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due t	stated. the cause(s)
To the within To the comp	(Check only 1 one) 2 29b. Signature ar	and manner s	stated.		nse number		29d. Date signed (	
	45	W, No		0.0	C.M.E.		April 29, 2009	
		idress of person who completed cau		21	MD 04304			
	Ling Li, MI		miner 111 Penn S	Street, Baltimore	9, IVID 21201			
Sta Regist	rar	PR 3 U 2009	egistrar's Signature	arke				

09-03399 Junius Butler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 13817

		- For State Registrar	Certifica	Reg.	Reg. No.			
Physicia	in/	Decedent's Name (First, Middle,La)	ast) R LI			Date of Death     Month     Date	av Year	3. Time of Death
ledical Exami		Junius S	, Dutley			April 25, 200		2022 hrs
		4a. Facility Name (if not institution, g		4b. City, To Timoni	wn, or Location of Death	٦	4c. County of Deat Baltimore Co	
			ne-2300 Dulaney Valley Road			R Date of Birth/	MM/DD/YYYY) 9. Bi	
Funeral Director		,	Sex 7. Age (In yrs. last birt	Months	1		Fore	ign Mary land
Director		- 1 14 10 17	XM 2 F 83	Yrs.		112-5-	1925 0	ountry)   100 100
ž.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
ow any		Tod. State	12 11	•				1 Yes 2 No
daryland 28a-f show I at once.	흱	10e. Street and Number	Dalt	10f. Zip (	Code	10g.	Citizen of What Co	untry?
e Mar or 28s	Director	Toe. Street and Number	( 1. 1.		21207		11 5	$\mathcal{A}$
ith the 23a contif		2 2 WINDS	12. Was Decedent Ever in U.S.		nt of Hispanic Origin? ( S	Specify Yes or No-	14. Race - Ame	rican Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Marri	ed Armed Forces?		Cuban, Mexican, Puerto		White, etc.	
ter de		3 Widowed 4 Divorce	1 Yes 2 No	1 Yes 2	No specify:		Specify: 13	lack
urs af tural amin	ğ	15. Decedent's Education (Specify	only highest grade completed) 16a.	Decedent's Usual C	Occupation (Give kind of	work done	6b. Kind of Business	s/Industry
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	_	king life. DO NOT use re	tired)	0	. 1
036 ithin r tha	립	10		On	ard		Secur	-1 14
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, La	st)		1	ie (First, Middle, Mai		/
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner.	a	Kodney Isu	Tley	l. Maritian Address	(Street and Number or	Gaine		to Zin Codo)
	욘	19a. Informant's N / (Relationship	(Type, Print)	2 - 2 1 . 1 4	L	hy Bal	Lul	21221
, MD and 2 sho ealth and em 27 is		20a. Method of Disposition	20b. Place	of Disposition (Nam	e cf cemetery,	70-9 P V	20c. Location - City	or Town, State
es 1 Se 1 Fe 1 Fe 1 Fe 1 Fe 1 Fe 1 Fe 1 Fe		1 Burial 2 Cremation	3 Removal from State	ory or other place)	1 4 4.	. /	RIL	1, 1
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other Special Signature of Funeral Service Lice		22 Name and	Address of Extility	iy / 2009	pa 10.	p.4
Balt permit. Departs Importinjury		21. Signature of Funeral Service Lic	Han lan	Carlto	C. Douglas	Funera	1 Service	- P-/1
Physician		23a. Part I. Enter the disease, or co	mplications that caused the death. Do n	ot enter the mode o	f dying, such as cardiac	or respiratory arrest	t, shock, or heart	Approximate Interval
'Medical		fallure. List only one cause on	each line. // a. Head injuries wi	th compli	ications			Between Onset and Death
.xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):					
		Sequentially list conditions,	b					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
ţ	хаш	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			· · · · · · · · · · · · · · · · · · ·		
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760, icate be gaphysicia the buris	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy		3 Ectopic preg	nancy	23d. Date of deliver Month	ery Day Year
Ox 68: ath certifi attending or use as 1	ian	past 12 months?	The transfer of the other	Fetal death  Other (Spec		nancy	I Month	bay roa
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unkno		o other topos				
that the d		Part II. Other significant condition	ns contributing to death but not resulting	ng in the underlying	cause given in Part I.			to the cause of death?
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ords, P w requires t as been sign should be of	lete					24a. Was ar autopsy		autopsy findings available o completion of cause of
eco re law te has ge 2 s	Completed					perform 1 <b>✓</b> Yes 2		
tal Rectingues The certificate ector, page		25. Was case referred to medical	T		26.Place of Death (Chec			
Vital Rec tysician: The this certificate director, page	o Be	examiner? 1 ✔ Yes 2 No	Hospital; 1 Inpatient 2 ER/C	Outpatient 3 D	Other Nurs	sing Home 5 R	tesidence 6 🗸 Ot	her: Scene
Sion of Vital Records, Attending Physician: The law requir redut. ector: After this certificate has been s by the funeral director, page 2 should I	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	Time of Injury	28c. Injury at Work?		ow injury occurred	k by auto
On tendii eath. or: A	Į.	1 Natural 5 Pendin 2 X Accident Investi	9 1/23/2000 2	20 pm	1 Yes 2 X No			
E	Certification:	3 Suicide 6 Could	28e. Place of Injury - At home,	farm, street, factory	, office building, etc.	or Town, Sta	ate) South (	Rural Route Number, City
Dital ours a filled	Sert	4 Homicide determ	(1921-197)			@ Easter	n Ave Bal	timore, MD
		29a. Certifier 1 Certifying Phy one) Medical Exam	sician: To the best of my knowledge, do iner:On the basis of examination and/or	eath occurred at the	time, date and place, a	nd due to the cause	(s) and manner as s nd place, and due to	tated.
Within To the comple	Medical		and manner stated.		c. License number		29d. Date signed (i	
	2	29b. Signature and title of certifier	•	290	O.C.M.E.		April 28, 2009	, = -71/
			harman and death (He-con-)					
			the completed cause of death (Item 23a) stant Medical Examiner 111	Penn Street, E	Baltimore, MD 212	01		
	tate			0.4		<del></del>	<del></del>	
Regis		11 11 11 11	NY Klewn A.	MARI	·····			

State Registrar 3001 SOUTH

ARNOVER ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ESMPILLA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \, \Box \, \Box \, \Box$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year ARTLETT 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Severna Park Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. 1 □ M 2 🗷 F Nov 7, 215-12-6636 Director 90 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, the Medical Exercitors is ust by notified at MD 1 ☐ Yes 2 ▼ No Director Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item—any injury or other traumait. 947 Juliet Lane 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 21 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unit (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ social worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Livingston Harris Evelyn Bockmiller ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Bartlett/spouse 947 Juliet Lane Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Ronal d Wade rector 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat C use (Final disease or condition resulting in death) Physician Can /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 sl 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: After this of funeral dire 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 2 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and may ner stated.

DHMH 17 Rev 1/2001

State Registrar ame and address of pers

31. Date filed (Month, Day,

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

TA

pe or Print in Black Indelible Ink. Ensure All Copies Are Legible.
MEND ITEM#30perDVR.G890,4/30/09,WS
tate of Maryland / Department of Health and Mental Hygiene
tems 5,7,18 per fb. 8891,56-09 vt
Reg. Nq2 [] [] S amend Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bowling **Physician** W. Month Karmel 27, 2009 7:45 A April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2426 Eugene Ave. Baltimore Co. Edgemere If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/02/1944 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 1 🕱 M 2 🗆 F Months Days Hours Country) Maryland 64 Yrs. **Director** -42-5241 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. The Medical Exercises. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Edgemere MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21219 2426 Eugene Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Longshoreman 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bowling Opal Blevins Daniel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 2426 Eugene Ave. Suzanne A. Bowling (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 05/01/2009 Towson, Maryland ature of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, MD 21222 Dundalk, Inc. 7922 Wise Ave. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ens disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2. No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐Yes 2 ☐ No 2 Accident investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and Itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. Paul Place 409 Chi-Shiang Chen 31. Date filed (Month, Day, Year) edistrar's Signature State Registrar

Please Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:42am 26,2009 **Physician** Curry /Medical Mary 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner saltimore Maryland Greneral If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Country) V A **Funeral** Days 1 ☐ M 2 🔀 F 95 219-09-8425 06-02-1913 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1520 West North Avenue Apt.#311 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify. 3altimore, Mar⁄yland 21215-0036 Specify: African Amer Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Memorial Nurses Aide 7th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 is marked o Curry Unknown Elsie Oscar ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grand daughter4310 Huntshire Road Randallstown, MD Hankspermit. Pages 1 and Department of Healt Important: If item 2: any injury or other once. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 05-01-2009 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee Leben Baltimore, MD 2121 638 N. Gilmor Street 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Alhelo Scle che **Physician** and 10 Vesco /Medical Due to (or as a consequence of): Examiner Hypertensian Esquentiary liet out different if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign be ( Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las | page 2 autopsy After this certificate funeral director, pag 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 l Nes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director /
completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

State Registrar 29b. Signature and title of certifier

Booker M Nessen MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN NAME 50) Delighin

32. Registrar's Signature

29c. License number

Delphin street, Baltimere MD ald17

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** April 08:55 P M 2009 Charles H. Chapman 143 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Levindale Hebrew Geriatric Center & Hospital Baltimore ŇA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F 081-16-0394 63 Director 09-07-1945 Guyana, West Indies Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int if Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show a notified at 1 ☐ Yes 2 ☐ No Catonsville Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l or USA 1023 Marksworth Road 21228 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Guyanese Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than ' vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Nirse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olga 2 Everette Chapman Havnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 Marksworth Road Catonsville, Maryland 21228 Florence Beverly Chapman - Wife Department of Health Important: If Item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-29-2009 Catonsville, MD Metro Crematory ture of Funeral Service Licensee 22. Name and Address of Facility 9200 Liberty Road Randall stown, MD andon 21133 Wylie Funeral Home PA of Baltimore, County 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Haumani Bala **Physician** mound /Medical Due to (or as a consequence of): **Examiner** Vehicle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-trans CERTIFICAL REPROVED BY MEDICAL EXAMINES Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) has been signed by the ge 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pertensiv 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an was an autopsy performed? certificate ha funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1: Yes 2 No Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Oriver of Auto Certification: 1 Natural
2 Accident Injury 5 Pending -13-2008 1 ☐ Yes 2 ☑ No 0721 investigation i Director: / Building IMPAC 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) JALT, MORR, M. d., 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide OAdWIT 5401 leisTersTown lond within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27. 209 068054 up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) west Beivedere Faltimore MP ZIZIT SIK MUR MD Avenue 2434

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 27, Day 2009 Year **Physician** Dorothy 5:50 P Blanche Carey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8213 Redmiles Lane Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07-12-1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F Maryland 220-10-8365 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meulical Examiner must be notified at once. 1 Yes 2 No Director MD Odenton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8213 Redmiles Lane 21113 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/CXNo Specify: Specify: 9 White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> Appliance Technician</u> Defense Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Bennett Minnie Mae Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8213 Redmiles Lane, Odenton, Maryland 21113 Michael E. Carey - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 05-01-09 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 - 4 week Immediate Cause (Final Physician ovas a wee disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-trans been signed by the attending physician and should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 □ Onknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

son who completed cause of death (Item 23a) (Type, Print)

rans Hwy Millers ville MI)

09-03241 Bryan Cook

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 13824

		- For State Registrar								Reg. No.				
	Physician/ Indical Examiner  1. Decedent's Name (First, Middle,Last) BRYAN  MICHAEI						оок		Date of Death Month April 22, 20	Day Year 109		Time of Dea 2011 <b>hr</b> s	th	
		4a. Facility Name (if not institution, giv 7929 31st Street	e street and number)			City, Town, o	r Location of	f Death		4c. County o		/		
Funeral Director		5. Social Security Number 6. Social Security Number 1 220 – 88 – 7388	7. Age (	(In yrs. last bir 4 8	Months Dave Hours Min						irth(MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD			
Maryland 28a-f show any <u>d at once.</u>	Ī	Usual Residence of Decedent  10a. State 10b. County  MD BAI	TIMORE	0c. City, Town	or Location		ROSEL	ALE	<u> </u>			d. Inside Cit	-	
ith the Maryland 23a or 28a-f sho	<u>D</u>	10e. Street and Number 7929 31st STRE	ET			Of. Zip Code	237		10	10g. Citizen of What Country?  U.S.A.				
r death w	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 2 If Yes, Give Year	verin U.S. XiNo	If Yes	Decedent of H , specify Cuba es 2 X N	n, Mexican,			14. Race White Specify:	, etc.	Indian, Blac	ck,	
21215-0036 hould be filed within 72 hours after and Mental Hygiene. is marked other than "natural", after event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	Tor Dates: high highest grade complete College (1-4 or 5+		Decedent's during mos	Usual Occupation of working life	ation (Give k			16b. Kind of Bus	siness/Indu	,		
21215-0036 Build be filed within 7 Mental Hygiene marked other than cevent, the Medica	Be Com	17. Father's Name (First, Middle, Last HOWARD	)	JOH	INSON			s Name (Fi	irst, Middle, M	laiden Surname)		IENNM	ANN)	
MD 212 id 2 should b ulth and Ment in 27 is mark aumatic eve		19a. Informant's Name/Relationship (1 MARY THEA COOK				ddress (Stre 31st				ber, City or Town	n, State, Zì MD	p Code) 212		
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is ninjury or other tranmatic		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 X Other Specify  21. Signature of Funeral Service Licer	ENIOMEMENT	e crema	tory or othe HTTL MF 22. Nar	MORTAL (	ARDEN ss of Facility	4-27 CVAC	CH/ROS	20c. Location - City or Town, State  BALTIMORE, MD  EDALE FUNERAL HON				
Physician /Medical xaminer		23a. Part I. Enter the disease, or comp failure. List only one cause on e Immediate Cause (Final disease a	olications that caused the ach line.  Cardiac a		ot enter the	11 CH				SEDALE, st, shock, or hea	art /	212. Approximate Between On Deatl	Interval set and	
۔ نظار	Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Convestiv  Due to (or as a conseq  Due to (or as a conseq	re hear	t dis	ease					J.			
ficate be executed 'g physician and the burial - transit	/Medical E	X UNPENDED	AMENDED PI 1	ine a-	b,PII	,27,pe	rME, g	891 5	5/5/09	TT		,		
Records, P.O. Box 68760, The law requires that the death certificate be executed teate has been signed by the attending physician and page 2 should be detached for use as the burial - transil	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at til		2 Feta	death 3 r (Specify)	Ectopic	pregnanc	У	23d. Date of Month	delivery Day	Y	ear	
P.O. B es that the designed by the be detached	<u>۾</u>	Part II. Other significant conditions  Diabetes mell:	contributing to death I	but not resultir	ng in the un	derlying cause	given in Pa	rt I.		bacco use contri				
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certif its after death. The this certificate has been signed by the attending la Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Completed				· · · -				24a. Was a autop: perfor	med?		osy findings a apletion of ca 2		
tal Fiam:	B B	25. Was case referred to medical examiner?	Unonital				ce of Death				-5			
F VII	힏	1 ✓ Yes 2 No	Hospital: 1 Inpatien		Outpatient Time of Init		Other 4	Nursing I		Residence 6		cene		
Division of Vital Brother Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigat		ar)	Time of Inji	1	jury at Work Yes 2	No		now injury occurr				
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	Certification:	3 Suicide 6 Could not determine 29a. Certifier 1 Contificing Physician	d (Specify)						or Town, S			_	ber, City	
To the Ho within 24 To the Fu completely	Medical	(Check only one) 2 Medical Examine	ian: To the best of my r:On the basis of exami and manner stated.			n, in my opinie					lue to the c	ause(s)		
	29b. Signature and title of certifier  (ar of Hada						C.M.E.			April 24, 20		, Day, rear)		
$\phi$		Pamela E. Southall, MD									· · · · · ·			
Sta Registi	-	31. Date filed (Month, Day, Year)	32. Registrar's		Med									

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 16:29 James Collins 2009 APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMO RE 17 J If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, (Month, Day, BALTIMORE TOSPITAL 5. Social Security Numberunk 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 80 Feb 21, 1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√☐ No Director MD Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1006 Park Valley Court 21208 USA Funeral unk 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No if Yes, Give Year or Dates: Specify: white P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2401 W. Belvedere Avenue Baltimore, MD Sinai Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation & Other (Specify) in state 21. Signature o Rona I d State Anatomy Board 655 W. Baltimore Street Wirector Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 20 /Medical Due to (or as a consequence of): **Examiner** Preumano torel Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 24 No 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 2 ER/Outpatient 3 DOA Certification: To 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **Natural** 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

P.O. Box 68760, Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit been signed by the attending p should be detached for use as t s certificate has be lirector, page 2 sl this funeral After death. within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital To the

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death

Baltimore, Maryland 21215-0036

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State Registrar

DHMH 17 Rev 1/2001

Medical

KANT Date filed (Month, Day, Year) APR 3 0 2009

4 Thomicide

(Check only

29b. Signature and title of certifier

Ka

MOSPITAL OF BALTIMORE

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Physician: To the dest of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RESOOO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	-	For State		State o	f Maryla		epartment Certificate		ealth and N Death	/lental Hy			09	138	326
		Registrar  1. Decedent's Nam	ie (First, Middle,	Last)				01 2	Julii	2. Date of De				3. Time of De	ath
Physicia	n		nn Crai							Month April .		^{ay} 2009	<b>e</b> ar	12:00 A	
/Medic Examin		4a. Facility Name (i			mber)		4b. City, 7	own, or	Location of Death			c. County of	Death		
)		11 Mist	y Lane						posit			Cec			
Funeral		5. Social Security N	1	6. Sex 1 □ M 212 F	7. Age (In yı		Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, D	a <i>y, Ye</i> ai	r) 9	. Birthp	lace (State or Fo	oreign
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h the	irec	10e. Street and Nu	mber				10f. Zip	Code			10g. C	Citizen of What	at Coun	try?	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Ever front crust by notified at	Funeral Director	11 Mist	ty Lane						21904			USA			
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s afte	by Fi	1 ☐ Never Marr 3 🛣 Widowed		If Yes, Gi	ve		1 ☐ Yes 2		Specify:			Specify: W			
hours tural'		341 Widowed	15. Decedent's	Year or D	rates:	16a D	ecedent's Usua	Occupa	ation		16b	Kind of Busir	ness/Inc	fustry	
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Ment Ment arkec aric e	ပ္	Edward 1	Podesta							Doran					
nd 2 shoulth and 27 is m		19a. Informant's N Christo	lame/Relationsh pher Cr	ip (Type.Print) aig/son					and Number or Rui Way Por					Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventral termination of the retination.			Cremation	3 ☐ Removal from	State 20t	p. Place of D cemetery,	isposition (Nam crematory or of	e of her place	e)	Date	20c.	Location - Ci	ty or To	wn, State	
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9 9 <b>E # 9</b>		/20	nen	1900	a con		Baltimo	re,	my Board MD 2120	1 055 W.	ва	1t1mor	e S	treet	
		23a. Part 1. Enter t shock, or nea	the disease, or a	complications that only one cause on e	caused the de each line.	eath. Do no	1		_		arrest,			Approximate Interval Betwee Onset and Dea	en
Physician		Immediate Cause disease or condition resulting in death)	on	a		6a	istr.	C	Can	er			- 4	that	
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ian: rtifica	Be C	25. Was case refer	rred to medical						26. Place of Dear		- ,	40 1 1	1163	2 1110	
hysic his ce I direc		examiner? 1 ☐ Yes 2 ≥	100	Hospital: 1 □	Inpatient 2	☐ ER/Outp	atient 3 DC	Othe	er: 4 🗆 Nursing H	ome 50 Res	idence	6 □Oth <i>e</i> r	(Specif	y)	
Attending Physician: The law requires that the death certifroles.  cotor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	ion:	27. Manner of Dea 1 Natural	5 Pending		of Injury oth, Day, Year	28b. Tir Inji	me of 2 ury M	8c. Injury Work		28d. Describe	how inj	ury occurred			
death death stor: / the f	icat	2 ☐ Accident 3 ☐ Suicide	investig 6	at ha	of Injury - At	t home farm			Yes 2□No	28f Location	(Street :	and Number	or Rura	l Route Number	r
ital or A rs after ral Directed in by	Certification: To	4  Homicide	determi				n, street, factory			City or To	iwn, Sta	ate)			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	Certifying	Physician: To the examiner: On the to and man	e best of my loasis of exam nner stated.	knowledge, iination and	death occurred or investigation	at the tin in my o	ne, date and place pinion, death occu	e, and due to the rred at the time	e cause e, date a	e(s) and man and place, an	ner as s d due to	tated. the cause(s)	
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		30. Name and add						-wor	non a	D BIE	CA	TAR	MD	21014	(
Sta	te	31. Date filed (Mor	nth, Day, Year)	32 F	Registrar's Sig	gnature						, -3			
Registra	ar	AF	PR 302	009 Per	eur ,	1. 4	rachel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND of MEN 260 F Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William F. 26th 2009 Carter 510P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 642 Harvey Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/08/1931 (In yrs. last birthday, **Funeral**  Birthplace (State or Foreign Country) Months Days 212-28-8408 1 M 2 □ F 77 Hours Min. Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Marical Fyantic rought by a suited once. 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1417 Reynolds Street 21230 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 **∑X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No White Specify: 3 Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maintenance Mechanic Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Elmer Carter unknown P 19a. Informant's Name/Relationship (Type. Print)
Debbie M. Dugger / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 642 Harvey Street, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Hayen Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Charles L. Stevens Funeral Home Inc. Victor P. Doda 1501 Fast Fort Avenue, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Physician Canca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the Innertal director, page 2 should be detached for use as the burial-transit physician als the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year 5 Other (specify) I □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has be rector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home -5 Residence 6 Nother (Specify House Medical Certification: To Hospital: Daughter's 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death.
neral Director: A
y filled in by the ft. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

10

30. Name and address of person

31. Date filed (Month, Day, Year)

30

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2835

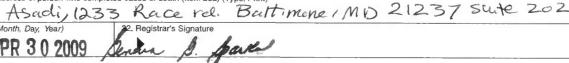
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2 per dr., g890,04/30/09dhb #5
Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04/15/2009 Month **Physician** 2:05 AM Mraaret /Medical 4a. Facility Name (If not institution, give street Manor Care -4b. City, Town, or Location of Death Examiner BaHimore 10WSOn If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday)
Yrs. 6 Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2**V**F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f shov must be notified at Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA death v 'natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed Black 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) House Keeper Private Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Si Henrietta Bolden ၉ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Health ar Important; If item 27 is any injury or other trauonce. Balto, Md. Husband 20a. Method of Disposition. 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) -24-09 Garrison Forest Owings Mills, Md. 21. Signature of Euneral Service Licensee Vaughin C. Greene Funeral Serv 22. Name and Address of Facility MO 155 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Syndrome Status Post Pacemen SICK Sinus /Medical Due to (or as a consequence of): Examiner Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit The law requires that the death certificate be executed y Pertension Due to for as a consequence of) Vital Records, P.O. Box 68760, by Physician/Medical ass attending IF FEMALE Se 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 No 9 Unknown 9 Unknown Land Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 2**⊠**No 1□ Yes 2₩ No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 MNatural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 3 0 2009

Cyrus

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** VIVIAN MARIE HOWARD ELLSWORTH April 25 2009 21:33 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BELAIR

Voor | If Under 24 Hrs. | Min. UPPER CHESAPEAKE MEDICAL CENTER HARFORD CO If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖾 F Yrs. 66 OCT 22 1942 VIRGINIA 227-58-5462 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2X No Director MARYLAND HARFORD CO **EDGEWOOD** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1557 CHRLESTOWN DR. 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 12036/es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ∐Yes 2XXNo Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER N/A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMAN HOWARD SR. ALICE HOWARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George L. Ellsworth Sr/Husband 1557 Charlestown Dr., Edgewood, Md. 21040 Injury or other Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05-06-09 4 ☐ Donation 5 ☐ Other (Specify) MAURY CEMETERY RICHMOND, VIRGINIA 21. Signature of Fun 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD, PA S PHILADELPHIA BLVD, ABERDEEN, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ere 515 disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown nis certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing/to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 2 No 3 Probably 4 Donknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 11 some autonsy performe 0 1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Division of Vital Records, P.O. Box 68760 the attending physician M000157374 this l or Attend after death Director;

the

filed within 72 hours after death with

Maryland 21215-0036

altimore,

Pages

H12512009

Certification: To funeral

5 Pending investigation 2 Accident 6 ☐ Could not be

3 Suicide 4 🔲 Homicide

29a. Certifier

1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and little of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32.

Sillaion Ave. HdG, MD

within 24 hours a To the Funeral D

Medical

State Registrar

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Dr. Jonathan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

BALTIMORE, MD MD 21237 ROSEDALE, Approximate Interval Between Onset and Death 23d. Date of delivery Day Year Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Hansen, 9000 Franklin' Square Dr. Baltimore, MD 21237

3830

3. Time of Death

9. Birthplace (State or Foreign

U.S.A.

WHITE

(SHOEMAKER)

Black, White, etc.

PENNSYLVANIA

10d. Inside City Limits

1 ☐ Yes 2 X No

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filled in by

Medical

within 24 hours a

To the Funeral C

completely filled

State Registrar

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Jak. Ensure All Copies Are Legible. Amend 23a, 28a, per ME g891 5/8/Jk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yea Month **Physician** 2009 Patrick Frederick 1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** 82 Trade Wind Circle Baltimore Cockeysville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Days Hours XXM 2□ F 46 5,1962 Maryland 219-86-9313 Sept. Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amounts in items 23a or 28a-f show amounts in items 23a or 28a-f show amounts in items in the Indifficult at once. Maryland Baltimore 1 □Yes 2\No Cockeysville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 82 Trade Wind Circle 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □Yes 202 If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □Yes XXNo Specify: White Baltimore, Maryland 21215-0036 Specify: <u>8</u> Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Credit Card Elementary/Secondary (0-12) 12 College (1-4or 5+) Printing Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Philip Patrick Frederick Dorothea Becker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Philip Frederick 3740 Beech Avenue, Baltimore, Maryland 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Atlantic Crematory 4/29/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Lic Inc. 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a pinsequence of): **Physician** disease or condition resulting in death) /Medical Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate | 1 Yes 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 □ No Medical Certification: To After this 28a. Date of Injury
Fd (Month, Day, Year)

Por 127 2009

28b. Time of unk Injury
Wo
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28c. Injury
Wo
10

28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of **unk** lnjury at Work?

M

28c. Injury at Work?

1 □ Yes 28d. Describe how injury occurred Sel+ 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 No a cong Tions within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 6 ☐ Could not be à Home To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau e(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) Troimble Hill 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FREUDENTHAL CLAIRE 227 21:21 PM 2009 4a. Facility Name (If not institution, give street and number 4c. County of Death Ballinge Sinai Hospital Walk unse N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Count ND 7. Age (In yrs. last birthday) 8. Date of Birth 11/10/1917 1 □ M 2 🛣 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE MD 1 ☐Yes 2X☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 1 POMONA EAST #207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes XXNo Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ART COMMERCIAL ARTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN **STROMBERG** BERTHA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 WASHINGTON AVE NEWTON, PA 18940 19a. Informant's Name/Relationship (Type. Print) DR. NANCY FREUDENTHAL/ DAUGHTER Date 20c. Location - City or Town, State 20a. Method of Disposition 20b1Place of Disposition (Value of Comercial Commercial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/2009 RANDALLSTOWN, MD CHESED 5 ☐ Other (Specify) Signature of Fineral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that aused le death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch lin. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hydrati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 7 No 1 □ Yes

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Evaniner must be notified at

21215-0036

Maryland

Baltimore,

3

Mental

permit. Pages Department of Important: If It any Injury or or

or other traumatic

Pages 1 and 2 should be

Director

Completed by Funeral

Be

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ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Lineral Director: After this certificate has been signed by the attending physician and it filled in by the funeral director, page 2 should be detached for use as the burnal-transit yillied in by the funeral director, page 2 should be detached for use as the burnal-transit. Division of Vital Records, P.O. Box 68760,

Physician/Medical

ş

Be Completed

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

1 Yes 2 1 No

27. Manner of Death

1 Natural

Accident

3 Suicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Impatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be

29c. License number 068810

SINAI

29d. Date signed (Month, Day, Year) APRIL 2009

BAZTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WEINTRUS

31. Date filed (Month, Day, Year) APR 3 0 2009

SHARON

32. Registrar's Signature

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4: 52 A M 25,2009 APRIL THOMAS Α GRIFFIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG • 17 Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Days Hours XXM 2□ F MARYLAND Director 1931 213-30-6306 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modral Experience" wast by nortified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2XXVo Directo MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8101 SALT LAKE DR. Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 28 ves 2 □ No If Yes, Give Year or Dates: 50/53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: BLACK à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POST OFFICE 12th grade MAIL HANDLER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS GRIFFIN MARY GRIFFIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5220 York Rd., Apt 6F, Baltimore, Md., 21212 <u>Barbara E. Griffin/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXXurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST :05/01/09 OWINGS MILLS, MARYLAND 21. Signature of Fuperal Servine L 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Extensive Sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 HOURS **Physician** INFARCTION MYCCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ARTERY 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? PIABETES 24 hours after death. • Funeral Director: After this certificate I 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 20656 PPODS, 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave., Baltimore, Maryland 21229 Zubelee, MD., Dr. K. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

A MOHL

SPIFFIE SPIFFIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day GREEN CHARLOTTE MAE **Physician**  $P^{M}$ 26, 2009 2:01 APRIL /Medical Town, or Location of Death TIMONIUM 4c. County of Death Facility Name (If not institution, give street and number)
STELLA MARIS HOSPICE CENTER 4b. City, **Examiner** BALTIMORE Birthplace (State or Foreign Country) last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-14-1940 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 ☐ ₩ 213-38-5676 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar must be notified at 1 ☐Yes 2 X No NOTTINGHAM Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 U.S.A. 4104 LOCHCARROW ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X□No Specify: Specify. WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FLORAL DESIGNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (TURNER) GREEN KATHLEEN CHARLES ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21236 LOCHCARROW ROAD NOTTINGHAM, MD DOLORES GREEN/SISTER 27 other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ţ, Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 4-30-2009 WOODLAWN, MARYLAND 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 호 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) HOSPICE Hospital: 1∐Yes 2XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident 24 hours after death Funeral Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr Medical 29a. Certifier (Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) X Nurse Practitionare stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar JACKIE JONES, CRNP 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

APR 3 0 2009

APR 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2:01

2009

CHARLOTTE GREEN

TIMONIUM, MD 21093

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 27 09 4c. County of Death 1533 mmon /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day Bon HOSPITAL

7. Age (In yrs. last birthdey) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Hours Days 1□M 2 F 69-32-7991 Mari Director ano Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Locetion 10d. Inside City Limits 10b. County 10a State 28a-f show of Health and Mantal Hygiana.
If item 27 is marked other than "natural", or items 23a or 28a-1 shor or other traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Tue 0 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VorKer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (niece) ρ 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other place) 1 Burial 2 □ Cremetion 3 Removal from State injury or Department c 4 ☐ Donation 5 ☐ Other (Specify) Ter 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Home 1222 W. North 23a. Partz. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocky or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Heurs Examiner Physician/Medical Examiner for use as the bunal-transit or Attending Physician: The law requires that tha daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Amoking Due to (or as a consequence of): After this certificate has been signed by the attanding funeral director, page 2 should be detached for use as 10 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobação use contribute to the cause of death? 1 Des 2 □ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Rhino Sinusitio 1 Yes 2 No 21/2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After t 1 DNatural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide o the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steled.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 32. Registrer's Signature 31. Dete filed State Registrar

DHMH 16 Rev 6/95

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 2:10 AM Apri Higgins 29 2009 W. mes 4a. Facility Name (If not institution, give street and number, 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore ear I If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Months Days Hours 213-30-3376 1 M 2□ F January 75 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 □ Yes 2 □ KNo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 7312 Manchester Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 1 No Black, White, etc 1 Never Married 2 Married 1 □ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years 3rd Helper Stool 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret G. Rayner James R. Higgins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7312 Manchester Road, Dundalk, Maryland 21222 Marleen Higgins wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State May 2,2009 Durdalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Connelly Funeral Home of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Maryland 21222 complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure a days Due to (or as a consequence of) Pri eumonia Sequentially list conditions, if any, loading to inimical accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (pres e consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 🗌 Yes 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

Department of Health a Important: If item 27 is any injury or other trainonce.

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Funeral

Director

of 2 should be filled within 72 hours after death with the Marylan th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'lle Marylan Examination at the marked at

3altimore, Maryland 21215-0036

Pages 1 and 2 should

permit.

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached

Examiner Physician/Medical ģ Completed Be Certification: To after death.

Director: Af
d in by the fu

1 Yes 2 No

25. Was case referred to medical examiner?

27. Manner of Death Natural 5 Pending 2 Accident 3 ☐ Suicide

4 Homicide 29a. Certifier

(Check only one)

investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

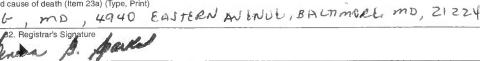
29c. License number RES - 000

29d. Date signed (Month, Day, Year) APRIL 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) r. CHUNG CECILLA mD

31. Date filed (Month, Day, Year)

APR 3 0 2009



within 24 hours a

To the Funeral C

completely filled

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Medical

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 12:30PM 26 2009 Susie A. Holley APRIL 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1100 Kenwood Avenue Balto N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 8-3-1941 MD 213-33-9924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1√DYes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1100 Kenwood Avenue 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2010 If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Towson University College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping 8th grade 17. Father's Name (First, Middle, Last) N/A18. Mother's Name (First, Middle, Maiden Surname) Millard Henry Bradley Eliza M. Pecker 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Kenwood Avenue Margaret Fitzgerald-Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 5-2-2009 Randallstown, MD * 4 ☐Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 years VASCULAR DEMCNTIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease, CAD. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26 Place of Death (Check only one)

Priysician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Items 23a

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permit. Page Department of Important: If any injury or once.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760

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Records,

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Be Completed by Funeral Director

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Examiner burial-transit Physician/Medical Completed by Be ၉ Certification: Director:

	4 Nursing H		7	6 ☐Other (Specify)
ry at		28d. D	scribe how inju	ury occurred

28c. Injury Work 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29c. License number

Ot

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eastern Ave, Balt, MD Z1224 4940 Matthew McNabres 32. Registrar's Signature

State Registrar 31. Date filed (*Month, Day, Year*) APR 3 0 2009

5 Pending investigation

6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Death

1 X Natural 2 Accident

3 Suicide

29a. Certitier

ical

4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) Physician /Medical Sel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 05–14–1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** 1 M 2 XF 60 FAIRMONT, NC Director 156-40-7455 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County 28a-f show must be notified at 1 XYes 2 No Director COLUMBIA HOWARD MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 5 U.S.A. 21045 9001 WATCHLIGHT COURT itеms 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) DISABLED DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) injury or other traumatic event, Be **JESSIE** BETHEA ALEX ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. 5495 CEDAR LANE, #508 COLUMBIA, MARYLAND 21044 ZUL HOSEIN - HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date RIVERDALE PARK CREMATORY 4/30/2009 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HOME 21. Signature of Funeral Service Licenses 108 W. NORTH AVENUE, BALTIMORE, MARYLAND 21201 Honold 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MucCardlol

Due to (or as a consequence of): Physician /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 3 Probably 1 Tyes funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Yes 2 5 Residence မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, completely filled in by City or Town, State) 4 Homicide To the Hospital evithin 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

Jasec

32. Registrar's Signature

Barks

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20a-c & 22 per FH G892 6/16/09 dk
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** Donald L. Hughes April 19, 1:59 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Apr 15, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 ₹ M 2 □ F 510-38-5451 Kansas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examinar near be notified at 1 ☐ Yes 2 ☑ No Director Prince George's MD Riverdale 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ō 4409 East West Highway 20737 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 ☐ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 🛣 No Specify: Specify: 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) healthcare nursing assistant unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any Injury or other trau James Glen/friend 1625 Taylor Avenue Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 Removal from State 5/15/2009 Alexandria VA Metropolitan 4 □ Donation 5 1 Othor (Specify) in state 21. Signature of Euneral Tryice 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MB--21201 Pope FH, 5538 Marlboro Pk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 □ Yes 2 -100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Matural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and

30. Name and address

of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year)

09-03258 Jasmon Jiggetts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

ismon Jiggetts		State of Maryland / Department of Health and Menta  For State Certificate of Death  egistrar		. No. 20	09 1384
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Baltimore, permit. Pages la Department of He Important: Fite injury or other tr	1	4 Donation 5 Other Specify:  21. Signifiure of Funeral Service Licensee  22. Name and Address of Facility  (alvin L. William 270 Fred Nitton Pa			
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Division tal or Attendi rs after death. al Director: /	Certification:	2 Accident Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S	State)	Rural Route Number, City
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To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date	and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (April 24, 2009)	wonur, Day, rear)
	}	30. Name and address of person who completed cause of death (Item 23a)  111 Popp Stroot Baltimore MD	21201	<u> </u>	
l √ Sta	ate	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD  31. Date filed (Month, Day Year)  APR 3 0 2009  32 Kegistrar's Signatur  APR 3 0 2009	Z 1ZU1		
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me	ental Hygier	ne
			1 - State Registrar Certificate of Death	Reg.	No.2000 1381
П	Physici		1. Decedent's Name (First, Middle, Last)  SUBLIA  JONES	2. Date of Death	Day 2 Year 7/12 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b City, Town, or Location of Death	1 5	49 County of Death
	F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
ii.	Funeral Director		0.1.7 CO 0.0.0.0 1□ M 2 F F F / Vrs Months Days Hours Min.	(Month, Day, Yea 11-22-19	ar) Country)
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryla f sho	tor	MD NA Baltimore		1 X Yes 2 No
	or 28a	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	s 23a	eral [	1502 West Lexington Street 21223		USA
<b>'</b> O	be filed within 72 hours after death with the Maryland the Wighen Hygiene. do ther than "natural", or items 23a or 28a-f show event, if a l'edical Expelient must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Tyes 2 1 No	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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212	d withi	Completed by	Elementary/Secondary (0-12)		Mercy Medical Ctn
pu	be file tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (	,	len Surname)
Maryland	d Men marke matic	2	Clyde Jones, Sr. Victor  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural		Owens
Z	nd 2 sl alth an 27 Is i		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural  Netina Alford - Daughter 1241 Walker Avenue		
ore,	es 1 a of Hea of Item fitem		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State	ate 20c.	Location - City or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the filediest Examinatement be routified an once.		4□Donation 5□Other (Specify) Arbutus Mem. Pk. Cem.	5-1-09	Arbutus, MD
Bal	permi Depar Impor any ir				ral HomeP P.A. ltimore, MD 21217
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between
S. A.	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Pulmonwy y Hypey to	N2101	Onset and Death
r í	/Medical Examiner		Due to (or as a consequence of):	DAIRIN	WINNYS 5 LEAVS
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter I Indexiving.  Due to (or lat a consequence of):	1010001	
36	ecuter and transi	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or in a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	5	Iweek
8760,	icate be executed physician and the burial-transit	dical E	d.		
89	ertifica ing ph	Φ.	IF FEMALE:		
Вох	leath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery  Month Day Year
P.O.	t the d	Physician/M	1   Yes 2   No 9   Unknown 9   Unknown		
S, F	w requires that the de been signed by the should be detached	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?
Sorc	requi	eted			2 No 3 Probably 4 Unknown
Division of Vital Records,	he law e has	Completed		24a. Was an autopsy performeg	24b. Were autopsy findings available prior to completion of cause of death?
ita	ian: T	Be C	25. Was case referred to medical 26. Place of Death	1 □ Yes 2 ☑ (Check only one)	No 1 ☐ Yes 2 ☐ No
<u>`</u> <	hysic this ce al direc				6 ☐ Other (Specify)
on .	ding f h. After funeri	tion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1  Yes 2 No	8d. Describe how in	ijury occurred
Visi	Atten er deat ector: by the	Certification: To	2 Decident	8f. Location (Street City or Town, St	and Number or Rural Route Number,
	oital or urs aft eral Dir illed in				
) :	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	e(s) and manner as stated.  and place, and due to the cause(s)
	vithir To th	Me	29h Stignature and Hits of certifier 29c. License number		Date signed (Month, Day, Year)
	1		108an 050236	AP	ril 23,2009
	D		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THA T. BONNCUM MO 30   ST PXVV PC BUL	TIMOR	LE MIN ZIZK
	Sta		31. Date filed (Mg/tth, Day, Year) 82. Registrar's Signature		) // 0   / 0
	Registra	ar	APR 30 2009 Senda S. Sparke		

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5-4574 04 12009 Lorraine N. Jamison-Hood 4c. County of Death 4b. Çity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) len Redical Center Isnr BUNG Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 14, Birthplace (State or Foreign Country) . 1931 Months Days Hours Maryland 213-28-4259 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2X No MD Anne Arundel Glen Burnie 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 USA 1612 Tieman Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ◯ No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masonry Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara M. Smith John H. Crispens 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Tieman Drive Glen Burnie, MD 21061 Mr. Paul Donald Hood, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 1, 2009 Glen Haven Memorial Glen Burnie, MD 21. Signatur o Funeral Sauce Licensee 22. Name and Address of Facility Singleton Funeral and Cremation Services, 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Fart 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (outs a consequence of): disease OVAY Y Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ) No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1-∰Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, **Division of Vital** within 24 ho

To the Fune

completely i

Janos

and burial-trar attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached certificate after death filled in by 24 hours a

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

77 is marked other traumatic event, If

Department of Health Important: If item 27 any injury or other trong.

Health a

Physician

/Medical

Examiner

Funeral Director

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Completed

Be

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifie

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

6 ☐ Could not be

1 **certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DY

0 Registrar's Signature

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 5:10 A M Apr 22, 2009 Rosie Joyce /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Ellicott City** Howard 3592 Fels Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 💢 F Yrs Director 217.24.4417 Dec 11, 1929 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard **Ellicott Clty** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3592 Fels Lane 21043 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. □Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ■Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LULK homemaker at home of Health and Mental Hygir If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver Scott Lottie Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Ham Daughter 3592 Fels Lane Ellicott City, MD 21043 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o Burial 2 Cremation 3 Removal from State May 04, 2009 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Garrison Forest, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the discase, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Montas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 24 No 2 46 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No rilled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0-53636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

KOVIN

31. Date filed (Month, Day, Year)

CAFWON

Box 68760

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MO

2 Registrar's Signature

charter Drive

Columbia MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28,2009 Month 9:30A Apr. Vingale Levine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella-Maris - Dulaney Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 29 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 □ , 1977 Months Davs Hours Min. 31 Yrs. 216 98 8448 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore Essex 10e. Street and Number 16 Browning Drive 10f. Zip Code 10g. Citizen of What Country? 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify. Specify: black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Dentist 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Levine Alfred Lefine Camille White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Chinquapin PKWY Alfred Levine (father) Balto, Md. 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) rbutus Memorial Pk. May 3, 2009 Bal 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 2009 Balto, Md Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused by shock, or heart failure. List only one cause on each line. St. Balto, Md. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner Examine

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

3

Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Actional Examination ust by Inviting at

Baltimore, Maryland 21215-0036

burial-trar

Physician/Medical

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Completed

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Certification: To

Medical

State

Registrar

IF FEMALE:

within 24 hours a

To the Funeral I

completely filled

Vital Records, P.O. Box 68760

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48							24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings availab prior to completion of cause o death? 1 □ Yes 2 □ No
25. Was case referre examiner?	ed to medical					26. Place of De	ath (Check only one)	*
1 Yes 2 N	io	Hospit	al: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	MOther (Specify) HOSPICE
27. Manner of Death 1 <b>X</b> Natural 2 □ Accident	5 ☐ Pending Investigation		a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28	e. Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm, stree fy)	t, facto	ory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,
29a. Certifier	☐ Certifying Ph	ysiclar	n: To the best of my kno On the basis of examina	owledge, death o	occurre	ed at the time, date and plac on, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)

29b. Signature and Itle of cartifier

one X Nurse Practitioner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

37. Registrar's Signature

APR 3 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month April 28, 17:20 Macomber 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dundalk 1914 Ormand Road 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day) 6. Sex Months Days Hours 1 XM 2 □ F November 13,1920 88 218--09-3035 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1914 Ormand Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glen L. Martin 12 years Shipping & Receiving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Coffey George Macomber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife 1914 Ormand Road, Dundalk, Maryland 21222 Marie Macomber 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April[®] 30. Baltimore, Maryland 2009 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, of complications that caused the death shock, or heart failure. List only one cause on each enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liscose or jury) that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

ral", or items 23a or 28a-f show Extraincer must be notified at

er than "natural",

Health and Mental Hygiene. em 27 is marked other than ther traumatic event, It e M

Department of Health Important: If item 27 any injury or other the once.

Director

Funeral

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Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar been signed by the should be detached has 3.2 s After this certificate h funeral director, page this within 24 hours after death.

To the Funeral Director A
completely filled in by the fi Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical ò Be Completed Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown 25. Was case referred examiner?

1 ☐ Yes

27. Manne of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

2□ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a, Was an autopsy 1 □Yes 2 □NO

Other: 4 \sum Nursing H	lome	5 Aesidence	6 ☐ Other (Specify)
		Describe how inju	

26. Place of Death (Check only one

28a. Date of Injury (Month, Day, Year) 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifie (Check o. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending

investigation

6 Could not be determined

Kiumarce Kashi MD 3029 Dundalk Avenue, Dundalk, Maryland 21222

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 3 0 2009 09-03373

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

6

in McCormick	1-	- For State Certi	tment of Health and Mentai H ificate of Death	Reg. No.	2000 120
Physicia		egistrar I. Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year 0152 hrs
al Examirء المحتام	_	KEVIN MCCORMICK	4b. City, Town, or Location of Death	April 27, 2009	. County of Death
	1	la. Facility Name (if not institution, give street and number)  Good Samaritan Hospital	Baltimore		N/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		-	(DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		093-48-2896 1XM 2F 5	2 Yrs. Months Days Hours Mir	05/04/19	56 NORTH CAROLIN
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, T	Fown or Location		10d. Inside City Limits
		ARYLAND N/A	BALTIMORE		1 X Yes 2 No
Aaryland 28a-f show 1 at once,	~ L	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
with the Mary ms 23a or 28a- be notified at		2206 CALLOW AVENUE	21217		U.S.A.  14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XXNever Married 2 Married 12. Was Decedent Ever in U.S	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	Rican, etc.)	White, etc.
ter dea		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: BLACK
ours af	d b		16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	.,	Kind of Business/Industry
6 n 72 ho an "na ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			MC/TRUCKS
within giene.	E I	12yrs 2yrs 17. Father's Name (First, Middle, Last)	GLASS INSTALLER  18.Mother's Nam	e (First, Middle, Maider	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	R.D. MCcormick		MCcormick	
21 nould bend Men is mar	흔	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number of		
MD and 2 sho alth and em 27 is raumati	- 1	Christina Carter/Daughter  20a. Method of Disposition 20b. F	753 Lennox St., Apt	Date 20c.	. Location - City or Town, State
Ore, ges l a t of He : If ite	İ	1 X X Burial 2 Cremation 3 Removal from State	rematory or other place)	-04 <b>-</b> 09 LA	NSDOWNE, MARYLAND
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'M∘dical ∡aminer	Ĥ	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive are pure to (or as a consequence of	therosclerotic cardio	vascular di	sease
		Sequentially list conditions.			
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60, ate be e shysicia re buria	Medi	IF FEMALE: 23c. If yes, outcome of preg	nancy	2	23d. Date of delivery
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Box 687 (e death certifice the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
- 4 >· 6			esulting in the underlying cause given in Part I.		co use contribute to the cause of death?  No 3 Probably 4 VUnknown
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aw req	Completed			autopsy performed	
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Sion of Vital I Attending Physician: r death. ector: After this certifi by the funeral director,	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓			idence 6 Other:
of Vil ing Physic After this	일	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how	njury occurred
sion attendii death. ctor: /	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28f Location (Street	et and Number or Rural Route Number, Ci
Division of Vital Records, pipal or Attending Physician: The law require ours after death receipt Cartery After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	nome, farm, street, factory, office building, etc.	or Town, State	
Hospi 24 hou Funer tely fil		29a Certifier	dge, death occurred at the time, date and place,	and due to the cause(s)	and manner as stated.
To the Howithin 24 P. To the Furce completely	Medical	Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occurred		ed. Date signed (Month, Day, Year)
	2	29b. Algoriture and title of certifier	O.C.M.E.		pril 27, 2009
		30. Name and address of person who completed cause of death (Iter	m 23a)		
Ø V		Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	1201	
	State	A	ture A A		
Regi		renov	ORIGINAL		
DHMH 17 Rev 1/	/2001		ORIGINAL		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) am **Physician** Ernest Milnes /Medical 4b. Sity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** If Under 24 Hrs. if Under 1 Year Date of Birth (Month, Day, ept 12 5. Social Security Number Birthplace (State or Foreign Country) 1111 k 7. Age (in yrs. last birthday, 8. Year) 1944 **Funeral** Months 1**∑**M 2□F Sept 64 314-46-3074 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, In Medical Examinational be notified a once. Baltimore Y☐Yes 2☐No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21226 USA 1521 Elmtree Street Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Race - American Indian. 11. Marital Status unk Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No white Specify \$ 3 Widowed 4 Divorced Completed unk un 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21201 Maryland General Hospital 827 Linden Avenue Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 NOther (Specify) in State 21. Signature of Funeral Service Licensee Konald State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtky, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) Physician /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) ned by the a detached for 9 I Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 **Z**/No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending investigation nours after death. neral Director: Af y filled in by the fur 1 ☐ Yes 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, within 24 hours a Hospital

> State Registrar

completely

(Check only one)

31. Date filed (Month, Day,

29b. Signatur

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

09-03285		Please Type or Print in Black Indel			ible.
Thomas Grason		State of Maryland / Departm		id Mental Hygiene	2009 1384
Dl		Registrar  1. Decedent's Name (First, Middle,Last)	ate of Death	Reg 2. Date of Death	J. INO.
Physicia Medical Examin	11/4	Thomas Grason McWilliams Jr			Day Year agost I
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	Location of Death	4c. County of Death
		1634 Pulaski Highway	Elkton		Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Yea  Months Day		(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		212-34-1075   1XM 2 F   75	Yrs.	Jan 10	, 1934 Maryland
any	ł	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		10d. Inside City Limits
m b how	اءِ	MD Cecil Ell	kton		1 Yes 2 X No
8a-f s	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
with the M s 23a or 2 e notified		245 Plum POint Road		21921	USA
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er deat	F	1 Yes 2 X No	1 Yes 2 X No		Specify: White
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15-0 filed v Hygi d oth		17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, M	
2121 vuld be fi Mental I marked	o Be	Thomas Grason McWilliams  19a. Informant's Name/Relationship (Type, Print)  15	b. Mailing Address (Stre	Dorothy Baughm	ber, City or Town, State, Zip Code)
MD 3	H			nt Road Elkton,	
e, N. I and Health			of Disposition (Name of control of other place)	emetery, Date	20c. Location - City or Town, State
altimore, mit. Pages I at partment of Her pportant: If ite		1 Burial 2 Cremation 3 Removal from State crema 4 X Donation 8 Other Specify:	tory or other place;		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signau e of Funeral S nyice Licensee	22 Name and Address	s of Facility Board 655 W.	Baltimore Street
		Am William	Baltimore.	MD 21201	7,55
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68760, certificate b nding physics se as the bun		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy		Ectopic pregnancy	23d. Date of delivery  Month Day Year
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D sspital hours meral	ဗီ	4 Homicide determined (Specify)  29a. Certifier (Cartifician Physician To the best of my knowledge determined)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ical	293. Certifying Physician: To the best of my knowledge, de (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or			
To T com	Medical	and manner stated.  29b. Signature and title of certifier		nse number	29d. Date signed (Month, Day, Year)
		Caral Lagonnia	0.0	M.E.	April 24, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
			Penn Street, Baltir	nore, MD 21201	
		31. Date filed (Month, Day, Year) 32 Registrar's Signature	ball		
Regist	ΕÜ	APR 3 0 2009 Denus A	gares		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>009</u> 10:29 PMM Mary Paige McGuirk April 18, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2211 Pennington Road Bel Air
If Under 1 Year | If Under 24 Hrs. Harford 8. Date of Birth (Month, Day, ) Sept 23, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Year) Months Days Hours 220-46-6534 1 □ M 2 💢 F Sept 88 Ĩ920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 □ Yes 2√□ No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 Pennington Road 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2XX No Specify: Specify: White 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Warner Paige Julia Edey 19a. Informant's Name/Relationship (Type. Print)
John McGuirk/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Pennington Road Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card or reprinally arrest, Approximate Interval Between

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any foilury or other traumatic event, the Medical Examiner in an the retified at once.

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burialthe attending p signed by to page within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

Fo the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

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Comple			24a. Was an autopsy performed 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
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0	1 ☐ Yes 2 DHO	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H	ome 5 Residence	6 ☐ Other (Specify)
ation:	27. Manner Leath 1 Latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)    28b. Time of   28c. Injury at   Work?   1 □ Yes 2 □ No	28d. Describe how in	jury occurred
Seninc	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
olcal (		visician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated		

29c. License number

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year, APR 30

Year)

2009

and manner stated

Registrar's Signature

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			For State Registrar		State of M	aryland	•	rtment of i rtificate of	Health and I <i>Death</i>	wentai Hy	giene Reg. No. 7	200	0 13051	Ω
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permit. Departr	any ir		21. Signature of Fu	l Cu d	nsee Wo	1100	)   22	. Name and Addre 1101	E. Nort	March h Aver	East ue B	F/H alto	, MD 21202	,
			23a. Part 1. Enter the shock, or hea	he disease, or con	nplications that cause one cause on each I	d the death.	. Do not ente						Approximate Interval Between	
Physic /Med	_		Immediate Cause disease or condition resulting in death)		a. Seps								Onset and Death	
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The law requires that the death certificate ate has been signed by the attending phys	use as the b	Physician/Medica	IF FEMALE:		230 If you outcome	of progner	201							
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aw requ	2 should	Completed				1				24a. Was		24b. Were a	autopsy findings available	$\dashv$
The la	page 2	ĕ									osy rmed? 2 No	death?	completion of cause of s 2 121No	
siclan; The	ector,	Be	25. Was case reference examiner?		Hospital:			Oth	26. Place of Dea					_
Attending Physiclan; r death.	eral di	은	1 ☐ Yes 2 ☐ 27. Manner of Deatl	h	1 Inpati 28a. Date of Inj (Month, Da		R/Outpatient 28b. Time of	28c. Inju	4 Li Nursing H	ome 5 ☐ Resi 28d. Describe			ecify)	-
tendin eath. or: Aft	the fun	l gi	1 Natural 2 Accident	5 ☐ Pending investigatio	n	iy, rear)	Injury		rk? ]Yes 2 □ No					
or At after d	d ii	ertification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of in	ury - At hor c. (Specify	ne, farm, stre )	et, factory, office		28f. Location (. City or To		Number or F	Rural Route Number,	
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this	ly filled	ပ	29a. Certifier (Check only	1 Certifying P	hysician: To the best miner: On the basis	of my know	vledge, death	occurred at the ti	ime, date and place	and due to the	cause(s) a	nd manner	as stated.	-
the H thin 24	mplete	Medical	one) 29b. Signature and		and manner st		on and/or my	29c. Licens		ined at the time,			nth, Day, Year)	_
7.≱ 5	8		b Z	ant &	; M. [	) ,								
			30. Name and ddr		completed cause of	leath (Item	23a) (Type, F	Print)	and .	, ,	. 1	0 1	2009 nore, MD212	3
	Stat	Pijde	Fang Y	in 56	O Loch	Kower	n Blue	d Good	Samarita	n Hospi	tal, I	saltin	nore, MD 212	5
Re	State	~	A	PR 30 2	UU9 Brien	w	9. p	and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:35 \$ **Physician** nomas NSN 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Butonsvill M If Under 1 Year | If Under 24 H NOW CMOS MG scincutoler WD at 20866 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 M 2 □ F 3-26-9212 10-27-1928 Director 80 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☐No Director MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 7299 Swan Point Way 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1950–53 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Self Employed Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental George Owens Elsie Taylor ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a 605 W. Chesapeake Ave. Towson, MD 21204 Alison Owens/Daughter item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 5-4-2009 Ellicott City, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. nature of Funeral Service Licenses M01044 W 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical the as ding IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MUMI NFARC 1 Yes 2 No 3 Probably 4 Denknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No USPHACO A 24a. Was an nas autopsy The page perforn DISORDE certificate SEIZURE 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. After Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

م Records, or Vital Division To the Hospital within 24 hours

> Registrar DHMH 17 Rev 1/200

29a. Certifier

(Check only one)

IASNEEM

29b. Signaturgrand title of certifier

31. Date filed (Month, Day, Year)

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Medical

State

Sm MH

Sare

and manner stated

2835

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗤 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

SUITE 203

29d. Date signed (Month, Day, Year)

MA 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G890, 4/30/09, WS

			for State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No.2	09	138	352
ı	Physici		Decedent's Name (First, Middle, La	st) Charles H. O'[	Onnell			2. Date of Dea Month	Day	Year	3. Time of	Death M
- and	/Medio		4a. Facility Name (If not institution, giv		Joinnen	4b. City, Town, or	Location of Death		pr 25, 200 4c. County			-/
	*		4652 Sh	eppard Lane			Ellicott Cit	у		Но	ward	
	Funeral Director			eyn 2□ F 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da)	h , Year) 23, 1928	9. Birthp Cour		or Foreign
	pu 🔉		Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Lo	ontion				Ta	04 1-14-01	
	Aaryla f sho	ō		oward	Jity, TOWITOT LO	CallOT	Ellicott Cit	.,			0d. Inside Cit 1 ☐ Yes	
	the the the the the the the the the the	Director	10e. Street and Number	ward		10f. Zip Code	Ellicott Cit		10g. Citizen of \	What Cour		1
	h with		4652 Sheppard Lane				21042			U.S.		
	ems a	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.\	Vas Decedent of Hi f Yes, specify Cubar		pecify Yes or No-	14. Rac	e - Americ	an Indian,	
5-0036	be filed within 72 hours after death with the Maryland tat I-ygiene. d other than "natural", or items 23a or 28a-f show event, it a Modical Era-dirar must be rediffed at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	1  Yes 27 No If Yes, Give√ Year or Dates:		Tes, specify Cubar	Specify:	o Ricari, etc.)	Specify	ck, White, o		
ر ک	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occupa kind of work done d	ition uring most of work	dina I	16b. Kind of Bu	usiness/Ind	dustry	
[2	vithin sne. than '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)	_	9				
N.	filed within Hygiene. Ither than "	S	17. Father's Name (First, Middle, Last)				ss Owner  18. Mother's Nam	o (Firet Middle	Maidan Surnam	Lumi	ber	
and	d be tental	o Be		rles Hugh O'Donne	all Sr		To. Mouter's Man			,		
ar Z	should ind Mer marke umatic	우	19a. Informant's Name/Relationship (			g Address (Street a	nd Number or Ru		Catherine		Code)	
<u>≅</u>	d 2 th a 7 is		Craig O'Donnell Son	· · · · · · · · · · · · · · · · · · ·	1	St. Michaels				State, Esp	oudo,	
ore.	- I 6 =		20a. Method of Disposition	20b.		sition (Name of natory or other place			20c. Location -	City or To	wn, State	
Ĕ	mit. Pages partment of cortant: If its injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ic Crematory	i	28, 2009	GI	en Bur	nie, MD	
baltimore	permit. Departi Import any inj once.		21. Sign to relect Fundral S. (New Licer	1 Broker		. Name and Address	neral Home	P.A				
			23a. Part 1. Enter the disease, or companies shock, of heart failure. List only	plications that caused the des	ath. Do not ente	er the mode of dying	Columbia Pi , such as cardiac	or respiratory arr	est,	43	Approximate	)
	Physician	1	Immediate Cause (Final disease or condition			nereatic					Onset and D	eath
	/Medical		resulting in death)	Due to (or as a conse	quence of:	WI COURT	Cor) Cer				o mor	W17
	Examiner	_	Sequentially list conditions.	b								
	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):							
2	execution and al-trar	xan	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):							
00/00	e be e siciar buria				4==							
00	rificate be executed g physician and as the burial-transit	edical		. d					7			
		5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi		1			23d. Dat	e of delive	erv	
	e deat he att	sician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Мо			'ear
	at the	Phy	9 Unknown									
ń	e law requires that the death cer has been signed by the attendir e 2 should be detached for use	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	derlying cause giver	n in Part I.		pacco use conti			
OIC,	requi	Completed	- CONC 000110	aut ung au	SCASE	<u> </u>		1 □ Ye	es 2 No	3 Prob	ably 4 🗍 U	nknown
בי	e law has t	nple						24a. Was a autops	y F	rior to cor	osy findings a npletion of ca	vailable use of
	n: Th icate r, pag	ဒီ						perform 1 □ Yes		leath? □Yes	2 🗆 No	
= :	siciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Deat					
5	ding Physician: The n. After this certificate h. funeral director, page	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	4 Li Nursing Ho	ome 5 Reside			/)	
5	nding th. : Afte = fune	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work?	es 2 No	200. Describe no	w injury occurr	<del>zu</del>		
2	r Atter ter dea irector irector by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	l nome, farm, stre <i>ify)</i>			28f. Location (St City or Town	reet and Numbers. State)	er or Rura	Route Numb	per,
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	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  Within 24 hours after death.  To the Fundral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one) 2 ☐ Medical Exam	yslcian: To the best of my kr iner: On the basis of examir and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the c red at the time, d	ause(s) and ma ate and place, a	inner as si	tated. the cause(s)	
i	Vith Com	Σ	29b. Signature and title of certifier			29c. License	number	1	9d. Date signed			
			Van U Mw	ne UD		121	461		April 7	27	2009	
-	201		30. Name and address of person who o			,						
_(	700		Parry A. Moore 31. Date filed (Month, Day, Year)	crossroads Med		sociates	4801 Do	rsey Hal	1 Dr. E	llicot	t City,	<b>1</b> D
	Stat Registra	~	APR 3 0 20	oz. giologi o digit	ature	-						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 4 1. Decedent's Name (First, Middle, Last) 26 26 2009 рм Peebles Geneve Hazel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Joseph Richey Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Days 1 □ M 2 🖫 F MD 219-12-9435 -11-1923 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√XYes 2□No N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 1526 Kennewick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □Yes 2 No Specify: Black Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)unk unk Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Benson James Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7826 Elberta Drive Severn, MD 21144 of Disposition (Name of Date 20c. Location - City or Town, State Michael Peebles-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Laurel, MD

29d. Date signed (Month, Day, Year)

200

5-2-2009

**Physician** /Medical

permit. Pages 1
Department of the Important: If ite any Injury or of once.

1 - For State Registrar

10a. State

MD

Funeral Director

Completed by

Be

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1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Evander must be rediffed at

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-trar To the Hospital or Attending Physician: The law requires that the death certificate be execu has e 2 s this certificate har within 24 hours arter co...

To the Funeral Director: Aff

Division of Vital Records, P.O. Box 68760.

21. Signature of Funeral Service License	ee	22. Name a	nd Address of Facility	March Ea	st F/H	
Deady	, Ware	<i>ــا</i> ا ا	Ol E. North	Avenue E	Balto,	MD 21202
23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Renal far wence of): wence of): wence of):				Approximate Interval Between Onset and Orath  World Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street Street
IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	I death 3 Ectopic			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions con	ntributing to death but not resi	ulting in the underlying	cause given in Part I.	23e. Did tobacco		to the cause of death? Probably 4 Unknown
Attial (fill	nilation			24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of successions 2 \( \square\$ No
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OOA Other: 4 \( \sum \) Nursing	Home 5 ☐ Residence	Other (Sp.	ecity) Hoshiel
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	ury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, Sta	and Number or F ate)	Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)

29c. License number

MD National Mem

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

LOBRICT

31. Date filed (Month, Day, Year) APR 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 0831 2009 6 lam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution give street and number, Examiner MOVE Hos 8. Date of Birth (Month, Day, Under 24 Hrs Age (In yrs, last birthday, **Funeral** Min. Months Days 1 M 2 □ F 68 214-38-5669 lan Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 Funeral 3227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 🔁 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) supermar abover LU 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be obe ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ю. oise Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signator of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cours shock, or heart failure. List only one cause on ed the death. Do not enter the mode of dying, Immediate Cause (Final disease or condition resulting in death) Physician /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): 68760, Physician/Medical requires that the death certificate as Box for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 3 Probably 4 Unknown 1 Tyes page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performe 2 No 2 **2** No 1 ☐ Yes Vital 1 Tyes Hospital or Attending Physiclan; : After this certification of tuneral director, p 25. Was case referred examiner? to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Spe ŏ 28b. Time of 28a. Date of Injury (Month, Day, Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ithin 24 hours after death.

5 the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated. To the 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifig ٥

State Registrar 30. Name and add

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \be 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month PR1 **Physician** Price 26 Mary I. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMOR AGNE HOSPITA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Jan 12, 1916 Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Mary Land 1 ☐ M 2 🕏 F <u>205-16</u>-2597 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Dunda1k 1 ☐ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21222 95 Kent Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MYo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>Ş</u> 3 Midowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernie Bailey James Monroe Weaver မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Elkridge, MD 21075 5806 Hunt Club Road Dorothy Smith ( Daughter ) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Bethlehem Steltz Reformed Church 129, 2009 Glen Roock, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature Funeral Service Licensee M00809 MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on exclimmediate Caulie (Final disease or condition resulting in death) the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 75YEARS OBSTRUCTIVE DISEASE Physician PULMONARY /Medical Due to (or as a consequence of): 3 DAYS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒ No 5 Other (specify) 9 ☐ Unknown 9 Unknown After this certificate has been signed by if tuneral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 XYes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No The 1 ☐ Yes 2 ☐ No **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1∐ Yes 2∭XNo 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30

CATON

AUENUE

900 SOUTH

BALTIMORE

MARYLAND 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar		State of M	1aryland		rtment of F rtificate of		Mental Hy	giene Reg. No	2000	3 13856
Physicia /Medic		1. Decedent's Name (F	First, Middle, Las	ELIZABE	TH TH		STOKE	S	2. Date of De Month APRIL 2	Da	ay Year 2009	3. Time of Death 10:54 a M
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Sta Registr		31. Date filed (Month,	Nich-las A. De Monaco 8926 Woodyard Road Scrife 201, Clinton, MD 20735 Date filed (Month, Day, Year)  APR 3 0 2009  APR 3 0 2009  APR 3 0 2009									

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygiene	2000 12057				
hysician	1. Decedent's Name (First, Middle, Las	5 M17H		2. Date of Death Month Da	7 7 7 0 84				
Medical xaminer	4a. Facility Name (If not institution, give BON SECOURS H	OSPITAL	4b. City, Town, or Location of Dea	c. County of Death					
neral ector	5. Social Security Number  223-24-9914  Usual Residence of Decedent	7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 8.4 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) VA				
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23a or 28a-f st ust be notified ral Director	10e. Street and Number 2725 Walbrook	Avenue Apt. #317	10f. Zip Code 2 1 2 1 6		itizen of What Country?				
"natural", or items 23a or 28a-f show cdient Examiner must be notified at leted by Funeral Director	11. Marital Status  1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puei 1 □Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: African American				
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sician edical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line.  Approximate Interval Between Onset and Death Clusse (Final disease or condition resulting in death)  Due to (or as a consequence of):								
ysiclan and und under burial-transit under cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):								
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To the comple	29b. Signature and title of certifier		1. Date signed (Month, Day, Year)						
7	30. Name and address of person who	completed cause of death (Item 23a) (Typ							
State	31. Date filed (Month, Day, Year) APR 3 0 2009	BON SECOUPS  32. Registrar's Signature  S. Sau	LI	I MONE 1	ANT LEW I MAILARY				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			partment of Health and Mental Hygiene 2009 1385 ( rtificate of Death Reg. No.					
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)	2. Date of Death  Ab. City, Town, or Location of Death  2. Date of Death  Day  Year  4c. County of Death					
Funeral Director	CI	The Johns Hopkins Hospital           5. Social Security Number         6. Sex         7. Age (In yrs. last birthday)           214-38-3913         1 □ M 2 √2 F         68	Baltimore City  If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)  OCT. 12, 1940  Baltimore City  9. Birthplace (State or Foreign Country)  OCT. 12, 1940  MD					
70	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	RE 1 X Yes 2 □ No					
21215-0036  d within 72 hours after death with the Manyland giene. ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	2108 BOSTON ST APT. #606  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Yes, Give Year or Dates:	10g. Citizen of What Country?  21231  Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:  ### WHITE  ### WHITE  ### Specify:  ### WHITE  ### Black, White, etc.    Specify: WHITE  ### WHITE  ### Black of Work done during most of working   DO NOT use retired					
and 2121 be filed within ttal Hygiene. ed other than event, the Me	To Be Completed	17. Father's Name (First, Middle, Last)	DRKLIFT OPERATOR FACTORY  18. Mother's Name (First, Middle, Maiden Surname)  ANNA LANG					
re, Mar s 1 and 2 sh f Health and tem 27 is n other traum		19a. Informant's Name/Relationship (Type. Print)  ANNA MAJKA/DAUGHTER  20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State  10b. Ma  20b. Place of Disposition cernetery, or	ematory or other place)					
Baltimore, permit. Pages 1 at Department of Hee Important: If Item any injury or othe		21. Signature of Euneral Service Licensee	22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM.  2007–09 EASTERN AVE., BALTIMORE, MD 21231  Inter the mode of dying, such as cardiac or respiratory arrest,  Approximate					
Physician /Medical Examiner	Examiner	shock, or heart failure dist only one cause on each fine.  Interval Between Onset and Death disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (usease or injury that initiated events  C.						
P.O. Box 68760, State the death certificate be executed by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	d	Ectopic pregnancy Other (specify)  Month Day Year					
I Records, P.O. The law requires that the tee has been signed by the page 2 should be detach	by	Part II. Other significant conditions continuiting to death but not resulting in the	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown  24a. Was an 24b. Were autopsy findings available					
	Be Completed	25. Was case referred to medical examiner?	autopsy performed?  1 □ Yes 2 ▼ No 1 □ Yes 2 □ No  26. Place of Death (Check only one)					
On ling l	Certification: To	1   Yes 2   No						
Hospital 24 hours Funeral tely filled	edical Cer	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
To the within 2 To the comple	Me	29b Signature and title of certifier  Audia Haus MD  30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)  29c. License number  29d. Date signed (Month, Day, Year)  ATTIL QU, QOO  600 North Wolfe St, Baltimore, MD, 2128					
Sta Registi		31. Date filed (Month, Day, Year)  APR 3 0 2009  32. legistrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yea **Physician** 2009 9:00 A APR MARTHA V. SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ESTHER'S PLACE - MONTEBELLO TERRACE BALTIMORE If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 5. Social Security Number **Funeral** Months Days 1 □ M 2 🛣 F 28. 1910 unk 98 Director 220-22-6330 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Evan. Two that be natified at 1X Yes 2 □ No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ESTHER'S PLACE death with 2831 MONTEBELLO TER. 21218 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status UNK 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 2 No Specify: BLACK Baltimore, Maryland 21215-0036 1 □Yes 2 No 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event; I to I and once. Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2831 MONTEBELLO TER., NATASHIA JOHNSON/CAREGIVER BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location City or Town, State 5712 O DONNELL ST. 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2009 BALTIMORE, MD 21224 MT. CARMEL 21. Signature of Fungral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. or complications that caused the List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final lav Year **Physician** 504 resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending p use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 m hths? 1 □Yes 2 ☑No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ! 1 □Yes 2 □No puthyroidism or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 🗆 Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

State Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

Kander 32. Registral's Signature

and manner stated.

MIL

31. Date filed (Month, Day, Year) APR 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Joseph Smith 7:41 P^M 27,2009 4c. County of Death /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Fayette Health & Rehabilitation n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

July 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ¼** M 2□ F 62 216 44 4994 Director S.Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Experience must be notified at MD n/a Baltimore 1⊠Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 415 E. Biddle St. USA Funeral or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: black ð 3 ☐ Widowed 4 🙀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Handyman Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental H John Junior Smith Lugenia Gibson permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic even 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lugenia Smith (mother) 415 E. Biddle St. Balto, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Green Mount Crematory of other place) May 4 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State <u>4</u>,2009 Baltimore, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Ignature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, Md. Immediate Cause (Final **Physician** acquired immuno defines Termina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. certificate be executed Exami and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed to d be deta Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □Yes 2 1 No 1 ☐Yes 2 ☐No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? After Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 931865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Gutare of Baltimore may Mian-Door Kionne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 3 0 2009 Registrar

1386

			1 - For State Registrar	otato or mar	yiaiia / L	Cert	ificate of l	Death	R	eg. No.			
	hysicia	an	1. Decedent's Name (First, Middle, Las	•					2. Date of Deat Month	th Day	Year	3. Time of E	
	/Medic		Willard Wade Smit		<del>.</del>		0 0: T	. I	April	26	2009 County of Death	6:26	РМ
E E	Examin	er	4a. Facility Name (If not institution, give Lorien - Mays Chape				Timoni	Location of Death	1		Baltimo	ro	
F	uneral		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birt	thday)_	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (State or ntry)	Foreign
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pur	3		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Towr	n or Loca	ation					10d. Inside City	y Limits
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the	r 28a- notif	irec	10e. Street and Number				10f. Zip Code		1	0g. Citiz	en of What Cou	ntry?	
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er dea	tems ler mi	unei	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	1	<ol> <li>Race - Ameri Black, White,</li> </ol>		
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d be fental	ked of	To Be	Cleveland Lafayett						Margaret		,		
shoul and M	s marl umati	Ĕ	19a. Informant's Name/Relationship (		19b	. Mailing	Address (Street	and Number or Ru	ıral Route Number				
and 2	n 27 le er tra	Ý	Christopher H. Bel	1/nephew				od Rd., U			ıthervil		21093
ges 1 tof He	If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	1		ition (Name of atory or other plac	,			cation - City or T		_
it. Pa	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specif		Green M	loun	t Cremato	ory Apr.	29,2009		Ltimore,		
Depa	any l		21. Signature of Funeral Service Licer	1/#		Jőf 200	n O. Mito E. Pado	hell IV,	Funeral S Timoni	ervi	ices of I MD 210	ulaney 93	Valle P.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do r							Approximate Interval Betw	veen
	sician		Immediate Cause (Final disease or condition	( moh	ahr	5	I de	wentra				Onset and D	eath
	edical miner		resulting in death)	Due to jor as a	consequence	of):	12 -th	2011				11.6.	- L
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e la w	has b je 2 sl	Completed							24a. Was a autops	sy	24b. Were aut prior to co	opsy findings a ompletion of ca	vailable use of
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sicla	s certi	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2   ER/Ou	utpatient	3□ DOA Oth		ath <i>(Check only on</i> lome 5 Reside		□Other (Spec	ih/)	
9 g	ter this neral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		Time of	28c. Injur Wor		28d. Describe h			(y)	
endin sath.	or: Af	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	1			M 1□	Yes 2 □ No					
or Att	Direct in by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined		/ - At home, fa <i>(Specify)</i>	ırm, stre	et, factory, office		28f. Location (S. City or Town	treet and n, State)	d Number or Rui	al Route Numb	er,
spital	neral			nysiclan: To the best of									
he Ho in 24 h	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Example)	miner: On the basis of e and manner state		nd/or inv			urred at the time, o	date and	place, and due	to the cause(s)	
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			On No Aread - Harris -	sempleted asset	th /Itom 20-1	(Type 5		0000	10	472	109		
			30. Name and address of person who	Cumpleted cause of dea	Lin (item 23a)		iles St	- PPE	269 1	Balt	more.	Md 2	1204
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	s Signature	1		1					
	Registr	ar	APR 3 0 200	19 Cerous	B. 1	Ja.	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA						

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Wonths Days Hours Min. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 145-20-3330 1 **X**M 2 □ F 1473071927 New Jersey 81 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show PA Adams Fairfield 1 XYes 2 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 10 Bunny Trail 17320 items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 1950–1952 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No ō, Baltimore, Maryland 21215-0036 Specify. þ 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Compensation Director Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Tylus Agnes Boczek ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Kevin Tylus / Son 15 Flanders Valley Court, Skillman, NJ 08558 t of Health If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Princeton Cemetery 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Department of I Important: If its any injury or o once. 04/24/09 Princeton, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Jer ice Licensee 22. Name and Address of Facility Mather Hodge Funeral Home T. Harman 40 Vandeventer Avenue, Princeton, NJ 08542 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest **Physician** 2hr disease or condition resulting in death) ) /Medical Due to (or as a consequence of). **Examiner** 4hr hypotensias Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Sue to for as a consequence of. or Attending Physician: The law requires that the death certificate be executed 3 years 0+ panareas mass CHILL and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Inpatient Other: 4 \(\home\) Nursing Home 5 \(\home\) Residence 1 X Yes 2 ☐ No 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 X Natural 1 🗌 Yes 2 🗌 No death. 2 Accident Director: A Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

(10)

) /2 V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Tsui The Kins Horpkun Hospital

31. Date filed (Month, Day, Year)

32. Degistrar's Signature

DHMH 17 Rev 1/2001

Registrar

RES-GGO

April 17,2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03259 State of Maryland / Department of Health and Mental Hygiene 2009 13863 Prince Ibrahim Trye 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day April 23, 2009 0830 hrs Medical Examiner Ibrahim Prince 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 8400 block Hunting Lane Laurel 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Foreign Min. Months Days Hours Country) Maryland Director 03/09/1995 218-43-9856 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show "natural", or items 23a or 28a-f shor Examiner must be notified at once. Maryland Prince Georges Laurel Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20708 ö 8922 Cherry Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces? 1 X Never Married 2 Married Yes Give Yea Yes 2 X No specify: Specify: **Black** Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 School 8 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sesay Prince Trye, Sr Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Prince Trye, Sr. - father 8922 Cherry Lane, Laurel, Maryland 20707 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Age, ment of H 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Other Specify: Maryland National Cemetery May 2, 2009 Laurel, Maryland Donation 5 22 Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Funeral Service Licensee M0(734 7601 Sandy Spring Rd., Laurel, Maryland 20707 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical physician a UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Por Yes 2 No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 No 3 Probably 4 Unknown ۵ Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? No 1 1 Yes certificate ✓ Yes 2 26.Place of Death (Check only one Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient ۵ 1 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c, Injury at Work? After 27. Manner of Death Pedestrian struck by train Certification Apr 23, 2009 0820 hrs Natural Yes 2 V No Division Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 24 hours after Suicide Could not be or Town, State) 8400 block Hunting Lane, Laurel, MD determined (Specify) CSX train tracks Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 24, 2009 O.C.M.E.

State

31. Date 160 Mont 32. Registrar's Sanature

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** 11:30 AMM April 15, John R. Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6614 Bushey Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F 218-28-4178 75 Yrs. Director July 11, 1933 South Carolina Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantinet must be notified at MD Baltimore 1
▼Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 Bushey Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: \$52-53 1 ☐ Yes 2X No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, to in doce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare pharmacist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby May Flowers Raymond Harvey Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6614 Bushey Street Baltimore, MD 21224 19a. Informant's Name/Relationship (Type. Print) Mary Lou Thomas/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Signalure | Luneral Service Licer | e de Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stuge Immediate C se (Final disease or consistion resulting in death **Physician** 104KS /Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physicians the burial attending p signed by the a d be detached for been si certificate has lirector, page 2 s this

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: After thi funeral c within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

dical	d.						
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ic. If yes, outcome of pregnancy  1  Live birth 2 Fetal dea  4  Pregnant at time of death  9  Unknown	ath 3 Ectopic			23d. Date of delivery Month Day Year	
Completed by Physician/Medical	Part II. Other significant conditions cont OSteomyeliks ( Coronum Arte	ributing to death but not resulting DEDOT  DISCUSSE		cause given in Part I.			ole
Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 🗆 [		ath (Check only one)		
Medical Certification: To	27. Manner / Death 1	28a. Date of Injury (Month, Day, Year)	o. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred	
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, facto	ry, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)	
edical (		ician: To the best of my knowled er: On the basis of examination and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)	
Me	29b. Signature and title of certifier	w		9c. License number	29d. [	Date signed (Month, Day, Year)	
	30. Name and address of person who cor						
	RITA MATHUR, M.D	9106 Philadeli	ohia Rd:	Ste 106, Balt.	MD 21237		
e ar	31. Date filed (Month, Day, Year)  APR 3 0 2009	32. Registrar's Signature	parked				

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First Middle, Last) Year **Physician** 08 05 AM Patricia G. Testoni APRIL 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. 6. Sex **Funeral** 1930 1 □ M 2XX Pennsylvania 164-24-0830 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Maryland 1 ☐ Yes XXNo Director Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 2300 Dulaney Valley Road W204 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White 'natural", or Specify. If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 🖔 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event. Baltimore County Elementary/Secondary (0-12) 12 College (1-4or 5+) School Teacher School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gallagher မ George Esther Kearnev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Testoni 108 Overcrest Road, Towson, Maryland 21286 Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/29/2009 Glen Burnie, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signatural Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** tastatio week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence offi certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an nas l page 2 Breast certificate 2 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Dipatient After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending ours after death. leral Director; Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058860 APRIL 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SHANN

31. Date filed (Month, Day, Year)

DHIL

MI)

Registrar's Signature

3333 N. CALVETLY STREET SUITE
33333 N. CALVETLY STREET SUITE

BALTO, MD

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 9	40-149	3	86	5 6	)
Cortificate of Death					

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experiment and the rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, State

	For State Registrar	State of Mai			tificate of L				Reg. No		UJ	100	000
	1. Decedent's Name (First, Middle, Last)						2	2. Date of De	ath			3. Time of	Death
n	NICOLA T.	AGLIAMB	URIS					Month 04	Da 2	4 Y	Year 2009	16:11	PM
r	4a. Facility Name (If not institution, give s.	treet and number)		T	4b. City, Town, or	Location	of Death		40	c. County	of Death		
	JOHNS HOPKINS BA	YVIEW MEDIC	AL CEN	TER	BALTIN	HORE						N/A	
	5. Social Security Number 6. Sex 15.	M 2∏ F	(In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Bir (Month, Da March	th ay, Year	1926		place (State on try)	r Foreign
	Usual Residence of Decedent		10.00										
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nue	11. Marital Status	<ol><li>Was Decedent Ev Armed Forces?</li></ol>		13. W	as Decedent of Hi Yes, specify Cuba	ispanic Oi n, Mexica	rigin? (Spec in, Puerto R	offy Yes or No ican, etc.)	)-		ce - Americ		
Ž	1 Never Married	1 ∐Yes 2X No If Yes, Give	)		□Yes <b>¾[X</b> No	Specify				Specif	v:		
	3 Widowed 4 Divorced	Year or Dates:	160	Danada	ent's Usual Occupa	ntlan			10h h	Cland of D	wsiness/Inc	White	
Set	15. Decedent's Educi (Specify only highest grade	completed)		(Give ki	ind of work done of NOT use retired	lurina mo:	st of working	9				ousny ern <b>a</b> tio	ona1
Ē	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)			hant Sea	•				Unic			01101
Pe C	17. Father's Name (First, Middle, Last)				name_sea		er's Name (	First, Middle,	. Maidei	n Surnan	ne)		
n o	John Tagliamburis	<b>.</b>				Par	rachev	vi Stav	ros	ki			
9	19a. Informant's Name/Relationship (Typ	774.6	e 19b.	Mailing	Address (Street a	and Numb	er or Rural	Route Numb	er, City	or Town,	State, Zip	Code)	
	Mrs. Katherine Tag	liamburis	14	15	Bonsal S	tree	t Bal	Ltimore	e, M	ary1	and	21224	
	20a. Method of Disposition		20b. Place of	Disposi	tion (Name of atory or other place	a) !	Da	te	20c. L	ocation -	City or To	wn, State	
	1 XBurial 2 ☐ Cremation 3 ☐ Re 4 Donation 5 ☐ Other (Specify)			awn	Cemetery	. !		/2009	Ва	11tin	nore,	Maryl	and
	21. Signature of Funeral Service Licenses	9. (c	LO	Du	Name and Addres da-Ruck 22 Wise	Fune:	ral Ho	ome of Malk, N	Dun Mary	dalk 1and	Inc. 2122	22	
	23a. Part 1: Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	he death. Do n		the first of the first of the first of the	1,1			-		10000000	Approximate Interval Bety	e ween
	Immediate Cause (Final disease or condition		CVP								12	Onset and D	eath
	resulting in death)	Due to (or as a	consequence o	f):								2 27 1	
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ledical Examiner	d.												
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an	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of 1 ☐ Live birth 2	☐ Fetal death		Ectopic pregnancy	/			1		te of delive		'ear
Pnysician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death	5 🗆 (	Other (specify)								
	Part II. Other significant conditions cont	ributing to death but	not resulting in	the und	derivina cause aive	en in Part	l.	23e. Did t	obacco	use cont	ribute to th	ne cause of de	eath?
Completed by			3		, ,							ably 426°U	
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	05.14							1 □ Yes	2 N		death? 1 □ Yes	2 🗆 No	
0	25. Was case referred to medical examiner?	ospital:	10		_ lotha			Check only o					
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2	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	( - At home, far	m etroe		162 2 🗆		of Location (	Ctrooto	es ed. A le com le	an on Dura	l Route Numi	
	4 Homicide determined	building, etc.	(Specify)	111, 50000	si, lactory, office		20	City or Tov	vn, Stat	e)	er or nura.	i noute ivanii	Jer,
medical certification.	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best of er: On the basis of e and manner state	examination and	, death o	occurred at the tin estigation, in my o	ne, date a pinion, de	nd place, ar ath occurred	nd due to the d at the time,	cause( date ar	s) and made,	anner as s and due to	tated. the cause(s)	
M	29b. Signature and title of certifier				29c. License	number			29d. Da	ate signe	d (Month, I	Day, Year)	
	1 dolphin				D-6	0611	15		AFR	12 21	4, 200	9	
	30. Name and address of person who con HARDIN PANTLE	mpleted cause of dea	th (Item 23a) (**  • EASTE	Type, Pr	rint) AVENUE	BA	LTIMOR	E MA		1224			
	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	0	AVENUE	*****	- 11-16-16-16-1	0, 100	-	4			
	APR 3 0 200	19 Breus	U B.	100	ale								

Registra

**Physician** Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. I Division of Vital Records.

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Exercities in the process.

/Medical

the burial-tran

21215-0036

Baltimore, Maryland

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 20

funeral

death.

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 2009

ORLANDO

29a. Certifier

(Check only one)

29b. Signature and title of certifier



dute

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CON

m

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10a per fh g890 4-30-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27,2009 Year Inez M. Taylor Apr. 9:40amM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien at Frankford Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days 220-18-4240 91 Director Nov.21.1917 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a Mbte 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified Funeral Director 13311 ☐ Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 1331 Pentwood Rd. 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced BLACK "natural" Pages 1 and 2 should be filed within 72 hrant of Health and Mental Hygiene. ant: If item 27 is marked other than "natuury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth Sewing Machine Operator American Golf Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemmuel Lewis Jackson Maryella Williams ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda White 1331 Pentwood Rd. Baltimore, Md. 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 ☐ Other (Specify) Arbutus Memorial PK.May 1,2009 Balto, Md. ic ature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, redicts Course (First) Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place o Death Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ner MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mremwoods Road - MD 21/28 harans y 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 30 Registrar Rowas

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 4 28^{Day} **Physician** 2009 4:29 PM Calvin Wilson, Sr T. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 33<u>12 Brendan Avenue</u> 8. Date of Birth (Month, Day, Year) 7-6-1941 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours Months 1 ★ M 2 🗆 F 67 Director MD 216-36-4734 Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mudical Examiner must be notified at 1 TyYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 23a USA Funeral 3312 Brendan Avenue 21213 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any Injury or other transfer. 1 ☐ Yes 2 ☐ No If Yes, Give X Ye ar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify Black 3 Wildowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD HospitalLaundry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvin Wilson Mildred Summerville ဂ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alternice Wilson Chasé-3312 Brendan Avenue Balto,MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 5-6-2009 Randallstown, Md March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M la 1101 E. North Avenue Balto, MD 21202 W our 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prostocke cance **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Year 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Injury ours after death. 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 h To the Fur and manner stated 29b. Signature and title of certifier 29c. License number DS7436 04/29/2009

State Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.0.

Division of Vital Records,

31. Date filed (Month



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Physici /Medic Examin	al
Funeral Director	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylant Department of Health and Mental Hygiane. Important: If item 27 is marked other then "natural", or Itams 23e or 28e-f show eny nighty or other treumatic event, the Maridial Exportant or other be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

G Division of Vital Records, P.O. Box 68760, ▼

	1 - For State Registrer			Cer	tificate of Deatl	h	Red	ı. No.	
	Decedent's Name (First, Middle, L.	ast)					2. Date of Death		3. Time of Death
n	Mabel Elizabeth	Walker					April 29	Day 2.009 Ye	6:15 P.M
al	4a. Facility Name (If not institution, g				4b. City, Town, or Location		- E	4c. County of D	
er :								Carr	011
	Long View Nursin  5. Social Security Number 6.		ge (In yrs. last	t hirthday)	Mancheste		8. Date of Birth	9	
	216-05-0639	1 ☐ M 2XXF	88		Months Days Hours	Min.	(Month, Day, Aug. 25,	1920 M	Birthplace (State or Foreign Country) laryland
	Usual Residence of Decedent						149. 257	1020	142 / 24114
	10a. State 10b. County		10c. City, T	Town or Lo	cation				10d. Inside City Limits
ō	Maryland Carrol	L	Ma	anche	ster				1 ☐ Yes 2 XXVo
ecl	10e. Street and Number				10f, Zip Code		10	. Citizen of Wha	t Country?
5	4002 Alesia Road				21102			citizen of Wha nited Sta	
era	11. Marital Status	12. Was Decedent	Ever in I.I.S.	13 \	Vas Decedent of Hispanic C	Origin? (Spec		America 14. Bace - A	American Indian,
Š	1 Never Married 2 Married	Armed Forces?	No.	1	Yes, specify Cuban, Mexic	an, Puerto F	Rican, etc.)		Vhite, etc.
γF	XXWidowed 4 Divorced	If Yes, Give Year or Dates:	440	1	I□Yes 201 No Specif	fy:		Specify:	White
Be Completed by Funeral Director	15. Decedent's			16a Deced	lent's Usual Occupation		1	6b. Kind of Busin	
iet	(Specify only highest g	rade completed)		(Give	kind of work done during mo	ost of workin	ig '	JO. TAING OF DUSING	o sa moustry
Ę	Elementary/Secondary (0-12)	College (1-4or	5+)		Seamstress			Cloth	nina
ပိ	17. Father's Name (First, Middle, Las	st)				her's Name	(First, Middle, M		illig
B									
၉	Thomas Elwood Bro			105 14-15-	g Address (Street and Num		ae Harri		to Zin Codo)
	Robert Walker (So	on)	20h Plac		Alesia Road			Dc. Location - City	
	12 Burial 2 Cremation 3	☐Removal from State	cem	etery, cren	sition (Name of natory or other place)	May	4,		
	4 Donation 5 Other (Spec	rify)	Blac		k Ch. Cem.			Slenville	e, PA
	21. Signature of Furielal Service Lic	ansae /		E	Name and Address of Fac CKNARGT FUNCT	dal Ch	apel, P.	Α.	
	CAMI COXIII CUL	D.		3	<u> 296 Charmil I</u>	Drive,	Manches	ster, Mar	27
	23a Part1. Enter the disease, or co	mplications that cause y one cause on each l	d the death. I ine.	Do not ente	er the mode of dying, such a	as cardiac or	r respiratory arres	it,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Pnow	mm	1					Onset and Death
	resulting in death)	Due to (or as	a consequer	nce of):				^	
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ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as	a consequer	nce of):	structure	Pulm	mary.	Visinse	· 1541s
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. arter	nsden	etic	Vasenda	Puln Di	mary.	Visiase	15ys 25ys
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ical Examiner	Cause (Disease or injury that initiated events	. arter	nsden	etic	Vascula	Pulm Di	mary.	Visinse	15ys 25ys
Medical Examiner	Cause (Disease of injury that initiated events that initiated events resulting in death) Last	. arter	nsden	etic	Vasculor	Pulm Di	many.	Disease	15ys 25ys
an/Medical Examiner	Cause (Disease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	. arter	s a consequer	nce of):	Vascular	Pulm Dr	mary o	23d. Date of	f delivery
sician/Medical Examiner	Cause (Disease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	s a consequer	otte nce of):		Pulm Di	mary.		
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	//aryla	lor			Glen										Yes 2√gNo	
	r 28a	Director	Maryland Anne Ar  10e. Street and Number	under	Gren		. Zip Code				10g. C	Citizen of V	Vhat Coun	itry?		_
	th with	al D	1133 Cedarcliff D	rive			2106	50			Un	ited	Stat	es		
2-0036	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, its the first Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.		ecedent of H specify Cuba s 2 🏋 No	ispanic Orig in, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	0-	Blac	e - Americ k, White, e Whit	etc.	an,	
ה ה	72 hou	Completed	15. Decedent's Ec	lucation	16a. D	ecedent's Sive kind o	Usual Occup	ation	t of working	a	16b.	Kind of Bu	siness/Ind	Justry		_
7	vithin ane.	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			f work done d T use retired Drive			7		Freig	rht			
7	filed v Hygie Sther i	ပိ	17. Father's Name (First, Middle, Last)			11 001	DITY		r's Name	(First, Middle						_
ומחם	Ald be Alental	To Be	Harry Clarence	Weckesser				M	Matil	da Hec	k					
lary	s 1 and 2 should by thealth and Menitem 27 is marked other traumatic		19a. Informant's Name/Relationship (							Route Numb					1 010	_
ອ໌ ຂ	1 and 2 Health Sm 27 ther tr		Richard Weckesse  20a. Method of Disposition	•					Jrive Da	, Glen		rnie,				) 
2	Pages nent of I ant: If its ary or o		1 DNBurial 2 □ Cremation 3 □	Removal from State	20b. Place of D cemetery,											
Банито	보본분들 .		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		Meadow					y L. K						_ n
ŏ	Depa Impo any ii		1 Carol Mi	hers		7250	Washi	ington	ı BLv	d.Ëikr	idge	e, Ma	ryla:	nd,	21075	.1
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the	e death. Do not	enter the	mode of dyin	ig, such as	cardiac or	respiratory a	arrest,			Approx	rimate Il Between	
4	Physician		Immediate Cause (Final disease or condition resulting in death)		GESTIV		HEAR.	T	ALL	URE					and Death	
4	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of)		1 57	ENO	215					1 in	DUTH	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of)				-31 -3					( 45 (	2.0 ( [4	_
	ocuted nd ransit	Examiner	that initiated events		E REA		FAILL	RE						20	744S	
0/00,	icate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a c	consequence of)		ACIP	0010						2 P	A + 1 65	
8	ficate physi s the t	dical		.d	POHC	-		2/3					4	ZV	4012	_
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death		oic pregnanc r <i>(sp</i> ec <i>ify)</i>	у				23d. Dat Mo	te of delive	ery Day	Year	
r,	s that gned b e deta		Part II. Other significant conditions of			ne underlyi	ng cause give	en in Part I.		23e. Did	tobacco	use conti	ribute to th	ie cause	e of death?	
ecords,	equire sen siç ould b	ted t	HYPERTENSION	DIABET						1 🗆	Yes	2 🗌 No	3☐ Prob	ably 4	4 Unknow	n
ဋ	e 2 sh	Completed by	GOUT	HYPTROH	ovestel	Port	ma			24a. Was	psy	l r	prior to cor	psy find npletior	lings available of cause of	е
אונפון	n: The ficate r, pag		STROKE							1 □ Yes		lo d	death? 1 ∐ Yes	2 🗆 No	)	_
5	yslcia s certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 □ ER/Outp	atient 3	DOA Othe	or:		(Check only ne 5 ☐ Res		6 □Oth	er (Specif			_
WISION OF	ng Phy ter thi neral o	n: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day, Y	28b. Tin	ne of	28c. Injur			Bd. Describe				'/		_
20	tendir eath. or: Ai the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	1		М	1 🗆	Yes 2 □N					<del> </del>			_
2	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	4 ☐ Homicide determined	building, etc. (						Bf. Location (	wn, Sta	te)			Number,	_
	he Hos in 24 ho he Fune pletely f	edical	29a. Certifier 1	nysician: To the best of a miner: On the basis of ex and manner state	xamination and/	or investig	ation, in my o	ne, date an pinion, dea	ith occurre	d at the time	, date a	(s) and ma	anner as s and due to	tated. the cau	use(s)	
	Vith vith com	Σ	29b. Signature and title of certifier	4			29c. Licens		/ /	İ		ate signe		-		
1				Houst			KEC	400	Q 7		A	PPIL	24	2	001	_
9	6 V		30. Name and address of person who DENNIS TERMU		th (Item 23a) (Ty	rpe, Print) S'H	TNOVI	ERS	7.	BALT	ПМ	opt	M	D, 0	21225	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	_								1			
DHI	Registr 4H 17 Rev 1/2		APR 3 0 2009	Genera,	1. par	the s										_
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State of Maryland / Department of Health and Mental Hygiene

sepii waik		1- For State Ce	ertificate of			20 (	19 138
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)  Joseph	Walk		2. Date of Death	n Day Year	3. Time of Death 1036 hrs
edical Exami	ner	4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of	April 24, 20	009 4c. County of Death	
		5624 Utrecht Road		Baltimore		Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under Months Days Hours	Min	h(MM/DD/YYYY) 9. Birt Foreig	n
Director		213-64-7911   1X M 2 F   55	Yrs		March	4,1954 Co	untry) MD
ny		Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Locati	on			10d. Inside City Limits
nd show s	_	Maryland Baltimore			Rosedale		1 Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Cour	
th the ? 23a or notifie		5624 Utrecht Road	T to in	2120		United	\
eath wi items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		s Decedent of Hispanic Orig es, specify Cuban, Mexican		White, etc.	can Indian, Black,
after de	by Fu	3 Widowed 4 X Divorced of If Yes, Give Year or Dates:	1	Yes 2 No specify:	·		nite
hours in matura	ed b	15. Decedent's Education (Specify only highest grade completed)		t's Usual Occupation (Give ost of working life. DO NOT		16b. Kind of Business/l	ndustry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years	As	sembly		General Mo	otors Corp.
5-00 led wit Hygien other the M		17. Father's Name (First, Middle, Last)		18. Mother	's Name (First, Middle, N	Maiden Surname) cia Marie (	) Molia
21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medica	) Be	William Charles Walk  19a. Informant's Name/Relationship (Type, Print)	19h Mailin	Address (Street and Num	- Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Company - Comp	5	AMERICAN CO.
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, tan: If Titen 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	ပ	Joshua Charles Walk (Son)	7973	St. Monica	Drive Dund	alk, Maryla	and 21222
re, N 1 and Health Fitem		A D and a Vancoustic a D Barrand from Class	crematory or ot	ition (Name of cemetery,	Date	20c. Location - City or	
Pages Pages nent of ant: I		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify	lltop Se	rvice Corp.	4/28/2009	Towson, M	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of interal Service to usee	22. 1	Dream Addes & Fail			
Physician		23a. Part I. Enter the disease, or complications that caused the deat	th. Do not enter t	7922 Wise Av	e. Dundalk cardiac or respiratory arre	est, shock, or heart	Approximate Interval
/Medical	1 19	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardio	vascular Dis	ease			Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence					
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):				
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):				
cecuted 1 and - transit		d.					<u> </u>
be esticiar	Medical	UNPENDED				120.0	
876( tificate ing physias the b		FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pre		etal death 3 Ectopi	c pregnancy	23d. Date of deliver Month	y Day Year
Box 687  e death certific  the attending   ed for use as t	sician/	1 Yes 2 No 9 Unknown g Unknown	death 5 0	ther (Specify)			
D.O. Box 687 that the death certific ned by the attending t detached for use as th	Phy	Part II. Other significant conditions contributing to death but not	t resulting in the	underlying cause given in P	art I. 23e. Did to	bacco use contribute to	the cause of death?
ords, P.O. w requires that the taben signed be should be detacted.	d by	chronic alcoholism			1Yes	2 No 3 Pro	bably 4 V Unknown
ords w requi	olete				24a. Was autop	sy prior to	utopsy findings available completion of cause of
Recol The law cate has	Completed				1 Yes	rmed? death? 2 No 1 ✓ Y	es 2 No
Division of Vital Records, rate and retuing Physician: The law required and returned and birectora. After this certificate has been sided in by the funeral director, page 2 should be	Be (	25. Was case referred to medical examiner?   Hospital: 4   Inscriper   2	ED/Outpeties	26.Place of Death	-	Residence 6 ✔ Othe	er: Scana
of Vi ing Physi After this uneral dir	. T	1 V Yes 2 No lospital 1 Inpatient 2  27. Manner of Death 28a. Date of Injury (Month, Day, Year)	ER/Outpatien 28b. Time of			how injury occurred	
Sion ( Mtending death. ctor: Af	tion	Natural 5 Pending		1 Yes 2	No		
ivision  or Attene after death Director:	Certification: To	Suicide 6 Could not be	home, farm, stre	et, factory, office building, e	etc. 28f. Location (5 or Town, 5		ural Route Number, City
Tig of Fi		4 Homicide determined (Specify)  29a. Certifier Check paly 1 Certifying Physician: To the best of my knowled	-d-a death con	seed at the time date and al	loca, and due to the caus	ce/c) and manner as sta	ted
To the Howithin 24 F	Medical	(Check only one) 1 Certifying Physician: 10 the best of my knowle one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investiga	ition, in my opinion, death o	ccurred at the time, date	and place, and due to the	ne cause(s)
P. N. P. 8	₩e	29b. Signature and title of certifier		29c. License number	OCME	29d. Date signed (Mo	onth, Day, Year)
		Theodon Ul. Kind Jana	a.D.	O.C.M.E.		April 25, 2009	
61		30. Name and address of person who completed cause of death (Ite Theodore M. King, Jr., MD. Assistant Medical		111 Penn Street, Ba	altimore, MD 2120	1	
	ate						
Regis			B. S.	arkel			
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# death with the Maryland

**Funeral** 

**Director** 

	ylan <b>how</b>	L	10a. State	10b. County		10c. City,	, Town	or Location	า			
	ith the Marylan or 28a-f show	Director	MD	Но	ward					Elli	cott Cit	ty
	哥 <b>6.</b> 13.	Dire	10e. Street and Nu	mber				10	f. Zip Co	de		
	ath wi		8541 Trail	View Dr.							21043	
	er deg	Funeral	11. Marital Status	_	12. Was Decedent I Armed Forces?		6.	13. Was I If Yes	Decedent , specify	of Hispanic Cuban, Mex	Origin? (S ican, Puerl	Specify Yes o to Rican, etc.
9036	72 hours after dear "natural", or items	ρ	1 ☐ Never Marr 3 ☐ <b>W</b> Widowed	fied 2 ☐ Married 4 ☐ Divorced	1 ∐Yes 2 M If Yes, Give Year or Dates:	No		1 □ Y	es 2	No Spec	oify:	_
215-(	hin 72 h e. a <b>n "natu</b> Medice	Completed	(Spe	15. Decedent's Edicify only highest grad	ucation de completed) College (1-4or 5	+)	(	Decedent's Give kind ( life. DO N	of work d	one durina r	nost of wor	rking
7	d witi	Son			4	'			Medic	al Tech	nologis	st
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventines must be notified at once.	To Be	17. Father's Name	(First, Middle, Last)	Foley	Gil	ch	Mst	-	18. M	other's Nan	me (First, Mid
ar	2 short and 1 is ma	•	19a. Informant's N	ame/Relationship (7	ype. Print)		19b. I	Mailing Ad	dress (St	reet and Nu	mber or Ru	ural Route No
Σ,	and 2 ealth n 27 i		Howard \	Warner Son			8	541 Tr	ail Vie	w Dr. E	llicott (	City, MD
ore	ges 1 ar it of Hea if item 3		20a. Method of Dis		D	20b. Pla	ace of [ metery	Disposition cremator	(Name o	f place)		Date
Ĕ	Pages ment of I ant: If ite ury or o			Cremation 3 ☐ 5 ☐ Other (Specify				ntic Cre			Apı	r 27, 200
Balt	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra		21. Signature of Fi	uneral Service Licens	Rhol	+Moi	792	22. Nai	Slack	ddress of Fa	l Home,	P.A. ike Ellico
			23a. Part1. Enter	the disease, or comp	lications that caused one cause on each lir	the death.	. Do no	ot enter the				
	Physician		Immediate Cause disease or condition	(Final	De cale on each in	- CA [	-01	10	-9	~70		
	/Medical		resulting in death)		Due to (or as	a conseque	ence of	): Jac	COV	,		
	Examiner		Communication line and	an aliai a ma	b. Cong	otivi	- 1	tear	7	aul	une	
	D #	iner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying		a consequ	ence of	):		3		
	ecute and trans	Examiner	Cause (Disease or that initiated events resulting in death)	S	· Hmo	JL	ul	WY	ete	m.		
30,	be ex cian a		resulting in death)	Last	Due to (or as	a conseque	ence of	):				
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Box 68760,	certiff iding se as	Physician/Medical	IF FEMALE:		23c. If yes, outcome	of pregnar	ncv					
Bo	atten for u	cian	23b. Was deceden	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 - Fetal	death		opic pregi er (specii			
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т, П	ned b	by Pł	Part II. Other signi	ficant conditions co	ontributing to death bu	ut not resul	lting in t	the underly	ing caus	e given in Pa	art I.	23e. [
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n c	ling F	ion:	27. Manner of Deat	5 Pending	28a. Date of Inju (Month, Da	ry y, Yea <i>r)</i>	28b. Tii Inj	ury		Injury at Work?	. □ N -	28d. Descr
Sic	ttend death stor:	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be	28e. Place of Inju	Inv - At hor	ne farn	n etroet fr		1 ☐ Yes 2	: □N0	28f. Location
Division of V	after of Direct of in by	Certification: To	4 ☐ Homicide	determined	building, etc	. (Specify,	)	ii, sileet, ia	actory, on	ice		City or
	To the Hospital or Attending Physici: within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral direct	Medical C	29a. Certifier (Check only one)		ysician: To the best iner: On the basis o	f examinati						
	the ithin 2	Med	29b. Signature and	Ltitle of certifier	and manner sta	ned.			29c. Li	cense numb	 oer	
	F 3 F 5		150	) ~ ~	0 ~				D	42 (	20	
			30. Name and add	ress of person who o	completed cause of d	eath (Item	23a) (T	vne Print	1	72-6	5 00	
	20 V		SARA	SHEIKH	P.	051 6	3AI			NATIO	NAL	PICE
	Sta	te	31. Date filed (Mor	אליים אות	32. Registra		ba	Ke 9				
	Registr	ar	APK	o U 2009	cerous.	10. 19						
DH	MH 17 Rev 1/2	001										
							0	RIGINA	VI.			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mary Elinor Warner Apr 25, 2009 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Somerford Place assisted Living Columbia Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 KF Yrs. 295-18-2335 Ohio Jan 12, 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No uneral Director MD Howard **Ellicott City** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8541 Trail View Dr. 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 FTYes 2 MANO 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 16b. Kind of Business/Industry Healthcare ddle, Maiden Surname) aar umber, City or Town, State, Zip Code) 21043 20c. Location - City or Town, State 9 Glen Burnie, MD tt City, MD 21043 Approximate Interval Between Onset and Death ry arrest, 23d. Date of delivery Day Month Year Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Nas an autopsy performe 2 No nly one) 6 Other (Specify) Residence ribe how injury occurred on (Street and Number or Rural Route Number, r Town, State) the cause(s) and manner as stated.

ime, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 4C ELLIGHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2 n /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 140-10 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 Director 220-18-5574 MD Aug 26, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exprainter must be recitled at 1 □Yes 2 No Completed by Funeral Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3208 St. Johns Lane 14. Race - American Indian, Black, White, etc. 21042 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h ပ Wilbur Herring Grace Montgomery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 l Mark Watkins Son 2023 Charolais Ct. Finksburg, MD 21048
Disposition (Name of Date 20 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of important: If its any injury or o of Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Crest Lawn Memorial Gardens
22. Name and Address of Facility Apr 28, 2009 Marriottsville, Maryland re of Funeral Se Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

Do not enjer the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the shock, or heart failule) List only one cause on each line. death. Immediate Cause (Final **Physician** 0 cm 610 disease or condition resulting in death) /Medical Due to (c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnent in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DDA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 No 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie and nanner stated. 296 Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (

of person who completed cause of death (Item 23a) (Type, Print)

Size has have, while

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19a/perFH. G890, 4/30/09 WS
State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 2009 7:56 A EMMA F. WILKS APR. 25. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 4012 ANNELLEN RD. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F Months Days Hours NOV. 21. 1924 Director 84 231-18-2226 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weden Examine Franch be notified at once. 10a. State 10b. County 1 XYes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 4012 ANNELLEN RD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🔀 No Specify þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING FACTORY SEAMSTRESS 12TH 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) ည CLARENCE ROANE DORA RINDER LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto 21215 D HMEILEN Roan C-Nephew Kelvin 4012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-5-09 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CO., MD WOODLAWN 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Pa . Enter the disea shock, or heart failure Do not enter the mode of dying, such as cardiac or respiratory arrest, plications that caused the one cause on each line. Immediate Cause (Final disease or condition resulting in death) CRCINOMO **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for selfs consequence of: Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the nast 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> FIC 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 500 24a. Was an performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 | Yes 2 🗓 № 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHIVIT IT ROVE 200

npleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		1- For State Registrar	Certi	ificate of Death		Reg. N		9   38
	ın/	Decedent's Name (First, Middle,Last)	-			Date of Death		3. Time of Death
ical Examii	ner	ATHENA M. WORRELL  4a. Facility Name (if not institution, give street a	and number)	Ab City Town	or Location of Death	Month Day April 25, 2009	4c. County of Death	1840 hrs
		1822 St. Paul Street Apartment (		Baltimore	or Eccation of Beath		to. County of Beauti	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) If Under 1 Ye Months Da		3. Date of Birth(M	M/DD/YYYY) 9. Birth Foreign	
Director		219-62-6595 1 M 2	∑F 48	Yrs.		DEC. 31,	0	ntry) MD
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
<b>*</b>	٦	MD	BAL	TIMORE				1 X Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Coun	try?
ith the 23a or notifie	a Di	1822 ST. PAUL ST		21202	Ennais Origina / Suppl	US tu Ves et Ne		an Indian Plack
5, NID Z 1 Z 1 2-10-30 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Arr	as Decedent Ever in U.S. med Forces?		an, Mexican, Puerto Ric		14. Race - Americ White, etc.	an inglan, black,
after de al", or ner m	by Ft	3 Widowed 4 Divorced If Yes, G	Yes 2 X No live Year	1 Yes 2 X	lo specify:		Specify: BLAC	K
JJO thin 72 hours aftene. than "natural", ledical Examiner		15. Decedent's Education (Specify only highe	, , , , , , , , , , , , , , , , , , ,	16a. Decedent's Usual Occup during most of working li			. Kind of Business/Ir	ndustry
bin 72 e. than "	Completed	Elementary/Secondary (0-12) Coll	lege (1-4 or 5+)	DISABLED			n/a	
filed within 7 Hygiene. d other than	S	17. Father's Name (First, Middle, Last)	<u></u>	DISABLED	18.Mother's Name (Fi	irst, Middle, Maid		<del></del>
ould be fil Mental F marked ic event, i	Be	LOUIS WORRELL		Town or W	MARIE CAF			=
d 2 shouldth and M	유	19a. Informant's Name/Relationship (Type, Prin	nt )	19b. Mailing Address (Str				
Health Item 2		ANTWOIN WORRELL 20a. Method of Disposition		Tope Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone Telephone T		ONSVILLI Date 20	c. Location - City or	
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rmit. epartm nporta jury o	1	21. Signature of Funeral Sarvice Licensee	/ //		ss of FacilityWESLE	EY CHAVIS	JR. FNI	RL. HM.
	4	23a. Part I. Enter the diasese, or complications	that cause the fleath [	2007–09	EASTERN AVE	E., BALT	MORE, MD	21231 Approximate Interva
hysician /Medical		failure. List only the cause on each line.	rhosis of		g, saar as cardiac or re	opiratory arrest, c	mook, or mount	Between Onset and Death
xaminer			or as a consequence of):					
	١.	Sequentially list conditions, b.	or as a consequence of):					
	min	cause. Enter Underlying Cause					93949, -36	
ted of Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or as a consequence of):				80,040 T.O.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Day Thomas Whalen J. 2009 26, 3:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Memorial Hospital Harford Harve De Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 9/23/1948 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 206-38-3082 1 XM 2 □ F 60 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Aberdeen Director 1. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 Funeral 131 Hanover Street, Apartment A USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates Completed by 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced Departm of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any Injury or other traumatic event, Ins. In coloral 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Whalen Anna Copley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Grutza / Daughter 217 N. White Street, Shenandoah, PA 17976 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 4/29/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services MOUSKON PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final nd Death **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER the burial-transi physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year ned by the a 5 Other (specify) I Yes 2 No Ö 9 Unknown 9 Unknown ۵, s been signed b should be deta Part II. Other 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 1 Tyes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ After this Division of funeral 27. Manner of Death
1 → Natural
2 □ Accident Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29c. License number 246 HEM 23a) (Type, Print) HARFORD MEMORIAL GOSTAL UNION AVENUE, HAVRE DE GRACE 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death (lonth Day Year :45PM 050 2009 Robert Joseph Atkinson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XXM 2□F Months Days Hours 579-48-6886 Dec. 25, 1933 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐Yes 2XX\No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2464 Frenchtown Road 21904 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes XXX No Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DONOT use retired) Real Estate Agent, Express 16b. Kind of Business/Industry Virginia Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years New York Courier-Owner Restaurant Mngr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert J. Atkinson Augusta Neiman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2464 Frenchtown Road, Port Deposit, Maryland 21904 Robert K. Dahl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date West Chester, 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Ferris & Co., Incl. 04/17/09 R.A. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania ure of Funeral Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home 21903-0766 Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Henorhae disease or condition resulting in death) Due to (or as a consequence of): sche Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident

Division of Vital Records, P.O. Box 68760, al or Attend s after death

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit this filled in by

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Execution. Once.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

Funeral

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Completed

Be

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with the Marylan

Physician/Medical \$ Completed Be Certification: To

Medical

25. Was case referred to medical

3 Suicide

(Check only one)

31. Date filed (Month, Day,

29a. Certifier

5 Pending investigation 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

agorate

29b. Signature and title of certific

npper

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who con npleted cause of death (Item 23a) (Type, Print)

parks

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

/Medical Examiner

Month **Physician** BRADFORD Lucille AGATHA 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death SINAL HOSPITAL OF BALT IMORE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director 219-08-6756 08.28.1929 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the freeign Exaction or other traumatic event, the freeign Funeral Director GLENN MD PRINCE GEORGES DALE 10e. Street and Numbe 10g. Citizen of What Country? 11304 STRAWBERRY GLENN 20769 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Tyes 2 No ģ Specify 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be f Health and Mental ELICE ္ဝ BELIVEN CAMPBELL LARIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 LESLIE BRADFORD - SPOUSE 11304 STRAWBERRY GLENN LN. Department of Heal Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ▶ Burial 2 ☐ Cremation 3 ☐ Removal from State GÉORGÉ 4 Donation 5 Other (Specify) WASHINGTON 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 01441 MEBEAN : ALSTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (List of that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by DEPENDENT DIABETES MELLITUL CORO NARY 24a. Was an autopsy performed 1 □Yes 2 1110 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1∏Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 140693 securit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

PEOPLES,

14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry PRIVATE GLENN DALE, MD 20769 20c. Location - City or Town, State 04.19.2009 ADELPHI, MD 1713 COUNTRYWOOD LANDOVER 20785 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) APRIL 7, 2009 HOSPITAL OF BALTIMORE

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 MNo

JAMAICA

8:11 PM

Year

2001

State Registrar

ALDEN

31. Date filed (Month, Day, Year)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** April 14, 11:30 P M Ethel Anna BELINKY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Nursing Home Silver Spring Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 6, 1908 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗔 F New York 577-36-6166 100 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No Maryland Prince Georges Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 3160 Gracefield Road 20904 United States Funeral items 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2X No Specify: Specify: white þ 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Rosen Sarah Paltrowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Jes 1 and 2 sh it of Health ar t: If item 27 I 20394 Ashcroft Terrace, Potomac Falls, VA Carolyn Donahue, Friend 20165 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If iter
any Injury or ott 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State Beth David Cemetery 04/17/09 Elmont, NY 4 Donation 5 Dother (Specify) 21. Signature of Functal Service Licensee Tởrchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has lirector, page 2 s autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours af

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the P within 24 To the F and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 44156 April 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rachelle Alexion, M.D., 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State APR 16 2009 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

sician and burial-trans physician s the burial attending ph certificate ha After this

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Registrar

Medical

4 Homicide

29a. Certifier

and manner stated. 29b. Signature and title of certifie

29c. License number 0033925

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date/signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) 101 COONIG mester 31. Date filed (Month, Day, Year) 32. Registrar's Signature

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth Year **Physician** 2311 M BRIA 2009 pn /Medical 4c. County 4a. Facility Name (If not institution, give street and number Town, or Location of Death Examiner Date of Birth (Month, Day, Y AN 12, If Unde 1 Year | If Under 24 Hrs. 5. Social Security Numbe . Age (In yrs. last birthda 9. Birthplace (State or Foreign **Funeral** Year 1944 WEST Months Hours 1 □ M 2 🔀 F **VIRGINIA** JAN. 65 577-56-8963 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show d other than "natural", or items 23a or 28a-f show event, the Medical Extraction in usit to profitted at 1X Yes 2 No Director ARLINGTON ARLINGTON VIRGINIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with UNITED STATES 1121 ARLINGTON BLVD. APT. 924 22209-3213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 **X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No Maryland 21215-0036 1 □Yes 2X No WHITE Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT ADMINISTRATIVE ASSISTANT marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be file and Mental E. 7 is marked ott Be HESTERS SAUNDERS JOHN P. BAILEY traumatic ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traum 500 DAKOTA COURT, CAROL STREAM, IL 60188 ERIC B. ROSADO/SON altimore. 20b. Place of Disposition (Name of CHESAPEARE CREMATEON Date 20c. Location - City or Town, State 20a. Method of Disposition APRIL 2009 3 ☐ Removal from State 1 ☐ Burial 2 X Cremation STEVENSVILLE, MARYLAND CENTER 4 ☐ Donation 5 ☐ Other (Specify) FEYEROWS Add HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami that initiated events resulting in death) Last burial-tran be exec Due to (or as a consequence of). Box 68760. physician Physician/Medical the attending phi for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by the best of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the signed of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 □Yes 2 No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ER/Outpatient 3☐DOA 1 Yes 2 🗌 No 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending (Month, Day, Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies Deput address of person who complete ause of death (Item 23a) (Type, Print) ~3 CV NE

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Year)

egistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				of Maryland / Dep			ental Hygie	ene				
			State Registrar	Ce	ertificate of De	eath	Reg	Reg. No. 2009 3				
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
	/Medic		Jeanne A. Berner				April 20	2009	5:50 a M			
	Examin	er	4a. Facility Name (If not institution, give street and i		4b. City, Town, or Loc			4c. County of Death				
			St. Mary's Nursing Ce		Leonardt		P. Date of Birth	St. Mar	-			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		lours Min.	8. Date of Birth (Month, Day, Y		* /			
	Director		Usual Residence of Decedent	88 Yrs.			09/15/19	20 Penn	sylvania			
	/land		10a. State 10b. County	10c. City, Town or I	ocation			1	0d. Inside City Limits			
	Mar a-f st	iot	Maryland St. Mary's	Hollywood					1 ∐Yes 2 X No			
	h the	Director	10e. Street and Number	120-27 1100	10f. Zip Code		10g	g. Citizen of What Cour	ntry?			
	th wit	al	41622 Beechwood Lane		20636		Un	ited State	s			
	ems	Funeral I	11. Marital Status 12. Was De Armed	ecedent Ever in U.S. 13 Forces?	. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,				
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Maryland	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Mai				e, Maiden Surname)  beby  ber, City or Town, State, Zip Code)  cod, MD 20636  20c. Location - City or Town, State  Charlotte Hall, MD  1d Funeral Home, P.A.  conardtown, MD 20650				
	rt 27		Susan B. Morrison/Daugh	ter 4162	2 Beechwood	Lane, H	ollywood	,_MD 2063	6			
Baltimore,	ges 1 ar it of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal fro	20b. Place of Disposemetery, cr	position (Name of ematory or other place)	Da	ate 20	c. Location - City or To	own, State			
Ē	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		4 □ Donation 5 □ Other (Specify)	Brinsfie	1d-Echols C	re 04/21	/2009 Ch	arlotte Ha	11. MD			
alt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee		22. Name and Address of	f Facility Bri	nsfield	Funeral Ho	ome, P.A.			
8	20 E # 9		Kyle S. Simons M012	00					20650			
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not e	nter the mode of dying, s	uch as cardiac or	respiratory arres	t,	Interval Between			
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	o (or as a consequence or).			l		J			
	and al-trai	xar	that initiated events c	o (or as a consequence of):								
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Ś.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	by F	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in	n Part I.		cco use contribute to t				
ord	w requir s been s should I		1 12:10 7	0 11	· 11		1 ☐ Yes	2 No 3 Prol	bably 4  Unknown			
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<u>=</u>	The	Completed	/		1		performe	ed? death? ■No 1 ☐ Yes				
Vital Records,	sician: The la certificate ha rector, page 2	Be (	25. Was case referred to medical examiner?	. Place of Death	(Check only one)							
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	ding Ph h. After th funeral	ioi :i	1 Naturat 5 Pending (M	te of Injury onth, Day, Year) 28b. Time Injury	Work?		8d. Describe how	injury occurred				
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_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, de	ath occurred at the time.	date and place a	and due to the cal	use(s) and manner as	stated.			
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	To the within 2 To the completed	Me	29b. Signature and title of dertifier		29c. License nu	ımber	290	d. Date signed (Month,	Day, Year)			
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	400		30. Name and address of person who completed de	ause of death (Item 23a) (Type	e, Print)	1						
	N		James P. Jarboe, M.D.	24035 Three 1	Notch Road,	Hollywo	od, MD	20636				
	Sta			Registrar's Signature	1							
	Registr	ar	APR 2 1 2009	Deverso B. A	Jan Jan							

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5:30 РΜ Clarence Joseph Bauer, Jr. 2009 April 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Taylor Farm Assisted Living Bushwood St. Mary's If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☑ M 2 □ F 202-12-6512 Director 85 October 10, 1923 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show the Medical Exaculture coust by notified at Director 1 ☐ Yes 2√∑ No 28a-f St. Mary's Bushwood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA or items 23a 21756 Oscar Hayden Road 20618 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No White Specify: by 3 ₩ Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Advertising Manager permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Joseph Bauer, Sr. Alma Krill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Bauer / Daughter 606 Radford Terrace, Leesburg, VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 24 Charles Memorial Gardens 2009 Leonardtown, Maryland of Funeral Service, 22. Name and Address of Facility Mattingley-Gardiner Funeral Home. P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Cardiac Event /Medical Due to (or as a consequence of): Examiner Minutes Coronary Artery Disease Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Years and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No P.O. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown <u> Hepatic Cirrhosis</u> Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy perform certificate 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 反 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D06419 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

NV

State

James P.

Jarboe,

M.D.

32 Registrar's Signat

21585 Peabody Street

Leonardtown, MD 20650

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who

31. Date filed (Month, Day,

SAJJA

Year)

TOLCHOUSE AVE. C-3 FREDERICK, MD.

eted cause of death (Item 23a) (Type, Print)

D

32. Registrar's Signature

BURRAL

801

			For State	State of	f Marylan		artment of H		Mental Hy		2000	13886			
	Registrar  1. Decedent's Name (First, Middle, Last)									eath		3. Time of Death			
	Physicia		Mary-Blue Battle									12:30 P ^M			
	/Medic Examin	_	4a. Facility Name (If not institution, gi	ve street and nun	nber)		4b. City, Town, or	Location of Dea							
•			Laurel Regional				Laurel								
	Funeral Director			Sex 1 □ M 2 🔀 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	8. Date of B (Month, D Nov • 1	irth Ba <i>y, Year</i> 3 • 193	9. Bird CC DC	hplace (State or Foreign buntry)			
ķ.	and the last		Usual Residence of Decedent												
	ylanc how at	,	10a. State 10b. County		10c. City	y, Town or Lo	ocation								
in the Mar	e Ma la-f s tified	cto	MD Prince	George'	s La	urel	10f. Zip Code								
	ith th or 28	Director	10e. Street and Number				ountry?								
	s 23a	<u>ra</u>	12221 Shadetree		edent Ever in U.	C 12	Was Decedent of H		(Specify Ves or N			rican Indian.			
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and son 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2⊠No /e		1 ☐ Yes 2 ☑ No	Specify:	erto Rican, etc.)		Black, Whit	e, etc.			
Ö	hours tura!"; al Exe	ed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's B	Year or Da	ates:	16a. Dece	dent's Usual Occup	ation		16b. F					
7	in 72 "nat	Completed	(Specify only highest g	rade completed)	1 (an E.)	(Give	kind of work done of DO NOT use retired	durina most of v	vorking						
212	with jiene. r thar the N	mo	Elementary/Secondary (0-12)	College (1	1-40r 5+)	Secre	etary			Date of Death Month Day Year April 12, 2009    4c. County of Death Prince George's					
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Las	it)				18. Mother's N	ame (First, Middi	· ·					
<u>Jar</u>	should be filed vand Mental Hygies smarked other tammarked other tammatic event, th	To E	Harold Eddins			·			MacGrego						
Baltimore, Maryland 21215-0036	nd 2 shouth and 27 is ma		19a. Informant's Name/Relationship (Type. Print)  Jon F. Battle/Son  19b. Mailing Address (Street and Number or in 12221 Shadetree Lane,												
ē,	s 1 and 2 of Health item 27 other tra		20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State			
Ë	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State I	. Linc	oln Cemet	ery 4/	18/2009	Bre					
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice	ensee	14.1h	2	2. Name and Addre	ss of Facility F	t. Linco	ln F	uneral I	Home 20722			
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between												
	Physician	i n	Immediate Cause (Final disease or condition  a. Convestive heart failure												
7	/Medical	Ĺ	resulting in death)		(or as a conseq		Larra								
b	Examiner		Sequentially list conditions, if any leading to immediate b. Chronic obstructive pulmonary disease												
	pe tis	igue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	ncer uence of):											
8760,	cate be executed physician and the burial-transit	dical E	•	d. Pne	umonia;	bilat	eral pleu	ral eff	usion						
စ	rtificat ng phy as th	ledi	IE EEMALS:					-							
Вох	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	tcome pf pregna pirth 2 ☐ Feta nant at time of d	al death 3	□Ectopic pregnancy □ Other (specify)	/							
o.	the de y the iched	ysic													
<b>ل</b>	s that ned b s deta	by Pr									id tobacco use contribute to the cause of death?				
5	w requires been sig should be	q pe	<u>Diabetes Mellitu</u>	S					_ 1[	Yes :	2 No 3 P	robably 4x Unknown			
Division or Vital Records, P.O.	e law re nas bee	Completed	Hypertension						– au	topsy	24b. Were a	utopsy findings available completion of cause of			
E	: The cate I	S	Chronic Anemia									s 2□No			
Ĭ	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		150/0 1	nt 3 DOA Oth	or:	Death (Check only		. To:: 10				
ō	Phys r this ral dii	년 :	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date	of Injury	ER/Outpatie	III OLI DOM	4 🗆 INUISIII				ecify)			
0	nding th. : Afte e fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	· ·	ith, Day Year)	Injury		k? Yes 2 ∐ No							
Visi	Atter er dea rector by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	a I Zoe, Place	e of injury - At he	ome, farm, st fy)	reet, factory, office		28f. Location City or 7	(Street a	and Number or F	Rural Route Number,			
	tal or rs afte al Dir ed in	Cert							4						
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		aminer: On the b			th occurred at the ti nvestigation, in my								
	To the within To the complete complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the c	Me	29b. Signature and title of certifier	٨	-		29c. Licens				ate signed (Mor				
			10/1	egle	·MD		1000	065418		F	April 12	, 2009			
	X		30. Name and address of person wh						1 1/0						
	U		Vitalis Ojiegbe,	MD, Lau	rel Reg	ional	Hospital	, Laure.	L, MD						
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 6 200	Jane	A.	par									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Gloria Swanson Bopst 23 2009 10:23 PM April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick 9330 White Rock Avenue Frederick 8. Date of Birth (Month, Day, Year) October 27, 1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 220-16-3208 1 □ M 2 🕱 F 85 Months North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 ☐ Yes 21 No Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 United States 9330 White Rock Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Tes 2 X If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🎛 No Specify Specify: Whit∈ 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Plouff 17. Father's Name (First, Middle, Last)
Charles Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9330 White Rock Avenue, Frederick, Maryland 21702 Susan Bopst / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Mount Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State April 27, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): TRACT Infects URINAM Sequentially list conditions, if any course in the Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-trans

been signed by the should be detached

page 2 s

certificate

After this certification funeral director, p

within 24 hours after death.

To the Funeral Director: completely filled in by the f

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

To the Hospital or Attending Physician:

**Physician** 

Examiner

10a. State

Director

Funeral

2

Completed

Be ပ

**Funeral** 

Director

f show

death with the

Pages 1 and 2 should be filed within 72 hours after

n and Mental Hygiene.

of Health a item 27 kg

Department of H Important: If ite any injury or ott once.

altimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner in ust be notified at

/Medical

Examiner Physician/Medical IF FEMALE:

3

Completed

Be

Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

23e. Did tobacco use contribute to the cause of death?

death?

24b. Were autopsy findings available prior to completion of cause of

2 No

Kanac Insufficience 25. Was case referred to medical examiner? 1 Yes 2 No

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

5 Pending investigation

Hospital: Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 ☐ Yes

26. Place of Death (Check only one)

perform

2 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

4 ☐ Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29b. Signature and title of certifier

29c. License number 0307 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1564 Opossumtown Pike, Frederick, Maryland 21702 Eugene B. Casagrande, M.D.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar



DHMH 17 Rev 1/2001

0 DK

Please Type or Print in Black Indelible Ink 3 Fasura All Copies Are Legible. Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 6890 14/30/05 Amend Item 20b per FH 689 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04-10-2009 **Physician** Helen Marie Carter 1:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 5507 Mt. Holly Road 4c. County of Death 4b. City, Town, or Location of Death Examiner East New Market Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0 8 - 1 4 - 1 9 3 4 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-32-0112 1 □ M 2 🛛 F 74 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show East New Market Dorchester 1 Yes 2 □ No MD r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21631 USA 5507 Mt. Holly Road or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify.White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private permit. Pages 1 and 2 should e filed within Department of Health and Mentel Hygene. Important: If item 27 is marker other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Baker 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Trice Ester Joyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 MT. Holly RD., East New Market, MD 21631 Thomas W. Schuyler Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/2009 4XDonation 5 ☐ Other (Specify) Howard University Washington, DC 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Rd., Easton, MD 21601 ature of Funeral S Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that constructions shock, or heart failure. List only one cause on e used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician mos. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician g Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 StNo Month Day Vear 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? 1 ☐ Yes 2 No 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 66270 30. Name and address of person who completed cause of dealing the a 23a) (Type, Print) mve#301 Eas 829 avid 31. Date filed (Month, Day, 32. Registrar Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Inky Frystre All Copies Are Legible.
Amend Item 29d per phys. G390 Inky Frystre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 3889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month APRIL 16,2009 **Physician** COLLIETA LEE CRABILL 1:47P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-31-1933 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F MD Director 220-28-5580 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Exprement must be notified at Director 1 ☐ Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 6663 Mt. Phillip Road 21703 **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In. Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Collieta Leon Crabill Mabel Emma Becker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Crabill Wife 6663 Mt. Phillip Road Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cm 4-22-2009 4 ☐ Donation 5 ☐ Other (Specify) | Adelphi, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Fungral Service Ligensee Mari M01176 106 East Church Street Frederick, MD 21701 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final THENO SCLENOSIS COROVANY ARTENY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) the 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? certificate 2 No 1 ∐iYes 2 💆 No 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAZHI, MD

224

29c. License number

Toll House Auc FREDERICK

D0047951

29d. Date signed (Month, Day, Year)

April 17, 2009

te of Maryland / Department of Health and Mental	Hygiene /	0 (	n	a	1	2	Ω	Q	Λ
Certificate of Death	Reg. No.	_ 0	U	2	ı	J	U	)	U

		for State Registrar	Otato of the	ar y laria /	Cer	tificate of				eg. No.	009	1389		
		1. Decedent's Name (First, Middle, La	ist)						ate of Deat		- Year	3. Time of Death		
Physicia /Medic		GENEVA				AP	RIL	9 , Day 2	009"	7:30 PM				
Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	Location of	Death		4c. County of Death					
		12625 Georgia				Silve:			ate of Birth		NTGOMI	ERY lace (State or Foreign		
Funeral Director			Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last	Yrs.	Months Days	Hours	Min. (A	1onth, Day,	Year)	Coun			
pu ,		Usual Residence of Decedent		100 City To	ONLIN OF LO	nation					11	0d. Inside City Limits		
shov	ö	10a. State										1 ☐ Yes 2 🎛 No		
28a-f	Director	10e. Street and Number	egomery		011	10f. Zip Code	1119		1	Og. Citizen	of What Coun	itry?		
with		12625 Georgi	a Avenue.	#101			906			-	U.S.A	-		
death ms 2	Funeral	11. Marital Status	12. Was Decedent			Was Decedent of H		in? (Specify Y	es or No-	14. F	Race - Americ	an Indian,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational be notified at once.	ξ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X I If Yes, Give Year or Dates:	No		r Yes, specily Cuba	Specify:	Puerto Rican	, etc.)		Black, White, $_{ m e}$			
72 ho	eted	15. Decedent's E (Specify only highest gr	ducation	10	6a. Deced	dent's Usual Occup	ation	of working		16b. Kind of	f Business/Inc	dustry		
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) -	`life. E	torial	d)	Ū		U.S.	Gove	rnment		
Hed w Hygie Iher ti		17. Father's Name (First, Middle, Las	r)					's Name (Firs						
d be f	Be	Cliff Cooley	,					-			iame)			
should nd Me mark imatik	ျ	Cliff Cooley Ana Thompson  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Table 19b. Mailing Address)										Code) 2090		
nd 2 saith ai		Anna Hutcher												
s 1 a		20a. Method of Disposition	_	20b. Place	e of Dispos	sition (Name of natory or other place	ce)	Date		20c. Locatio	on - City or To	wn, State		
Page nent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	1	ρf	Heaven	Cem					ring, MD		
permit. Departi Imports any Inj		21. Signature of Funeral Service Lice	ndee	Van S								ME, P.A. D 20850		
		3a. Part1. Enter vie disease, or con shock, or heart failure. List only	nplications that caused	the death	o not ente	er the mode of dyi	ng, such as c	ardiac or resp	oiratory arr	est,		Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition			ic B	reast C	'ancer	^				Onset and Death		
/Medical		resulting in death)	- u.	a consequen		20000								
Examiner	L	Sequentially list conditions.	b											
ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequent	ce of):									
execu and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as	a consequenc	ce of):									
ficate be executed physician and s the burial-transit			- d											
intificating phy	Medical													
eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnanc	nv.			23d.	Date of delive	•		
e dear	Physician/	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	Day Year		
d by t	Phy	9 Unknown		ut not requitie.	e in the co	adaduina asusa sir	on in Post !		230 Did tol	hacco uso c	contribute to th	no cause of death?		
w requires that the d s been signed by the should be detached	ξ	Part II. Other significant continuous continuous to death but not resulting in the underlying cause given in rare.									cco use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknow			
requ	etec							_						
has law	Completed							—   '	4a. Was a autops perforr	sy		psy findings available mpletion of cause of		
in: The		25. Was case referred to medical	Ţ				00 81		□Yes	2 PMo	1 ☐ Yes	2 □No		
s cert irecto	Be C	examiner?	Hospital:	ent 2 ☐ ER/	/Outnatien	ot 3 🗆 DOA Oth	or:	of Death <i>(Che</i> sing Home	:	·	Other (Specif	5/1		
g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	ıry 28	b. Time of Injury					ow injury oc		y)		
ath. rr: Aft	atio	1 Natural 5 Pending 2 Accident investigation	on	y, rear)	injury		Yes 2 □ N	lo						
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	20e. Flace of III	ury - At home c. (Specify)	, farm, stre	eet, factory, office			ocation (Si City or Town		ımber or Rura	al Route Number,		
Hospita 24 hours Funera etely fille	Medical C		hysician: To the best miner: On the basis of and manner st	of examination										
ro the	Me	29b. Signature and title of certifier				29c. Licens	se number		2	9d. Date sig	gned (Month)	Day, Year)		
174)		elleusso	u			MD F	onla	005	0	4	114/0	09		
7		30. Name and address of person who	completed cause of c	leath (Item 23	a) (Type,	Print)	11	,	1	/	1.0	0		
		malyukh Ho	SAIN, N.	D 1	221	Merca	ntile	40-	Lar	90,11	nD à	20714		
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	- 1									

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

16

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar		State of M	arylan	d / Depa		nt of H	ealth a		-	iene	13892
			1. Decedent's Name	(First, Middle, Las	t)							2. Date of Deat		3. Time of Death
	Physici /Medi		H <b>il</b> da	Mae C	coleman							April	11,2009	5:50 A M
	Examir		4a. Facility Name (If	not institution, give	street and number,	)		4b. City,	Town, or	Location of			4c. County of De	ath
			Corsica	Hills N	Nursing	Cent	er	Ce	entre	evil.	1e		Queen A	Anne's
	Funeral		5. Social Security Nu	mber 6. Se	7. A		last birthday)	If Unde	r 1 Year	If Under		8. Date of Birth	9. B	inthplace (State or Foreign Country)
	Director		217-12-4	4625	⊐м 2 <b>⊠</b> .F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Aug • 28	,1923 Ma	ryland
	D.		Usual Residence of I											
	how		10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
$\bigcirc$	a-f sho	cto	MD	Queen A	nne's	Qu	eenst	own						1. Yes 2 □ No
$\mathcal{A}$	with the a or 28s	ire	10e. Street and Num	ber				10f. Zip	Code			1	0g. Citizen of What	Country?
3	13a c	Funeral Director	713 Carı	michael	Rd			21	658				USA	
7	deat	ner	11. Marital Status		12. Was Decedent		.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No- Rican, etc.)		nerican Indian,
မွ	after or its	Ē	1 Never Marrie	d 2 Married	Armed Forces  1 ☐ Yes 2 🔀						i, Pueno F	nican, etc.)	Black, Wi	nite, etc.
8	al', c	þ	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	264 No	Specify:			Specify:	Black
21215-0036	72 hours after natural', or ite	Completed		15. Decedent's Edi			16a. Dece	dent's Usu	ai Occupa	ition	a = 6	_	16b. Kind of Busines	s/Industry
2	within 7 ane. than 'r	pie	Elementary/Secon	dy only highest grad	College (1-4or	5+)	life.	DO NOT U	se retired,	uring mos	E OF WORKIN	ig		
2	led wil lygien her tha	DO.	8	, ( )			Dome	stic	e Wo	rker			Private	Residence
	tal Hy d oth	Be	17. Father's Name (F	First, Middle, Last)						18. Mothe	r's Name	(First, Middle, I	Maiden Sumame)	
<u>a</u>	Menta Menta Brked	ToE	Charlie	Griffi	n					Hat	tie	Unkno	own	
Maryland	2 should and he is man		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									, Zip Code)		
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at		Elwood	Coleman			713	Carm	icha	ael E	Rd	Queens	town, MI	21658
<u>ත</u>	of Health of Hem 27 If		20a. Mathod of Dispo	osition		20b. P	face of Dispo emetery, crer					ate	20c. Location - City	or Town, State
SE.	y or			Cremation 3 □I 5 □ Other (Specify)	Removal from State	Ve	teran	's C	emet	zerv	4/17	/09	Hurlock,	Maryland
Baltimore,	artmontar ortar injur	. 4	21. Signature of Fun			- 11:11:				-				_
Ba	permit. Pages Department of I Important: If Ite any injury or of		> All	40000	1 -	>							eral Hom	
	-		23a. Part 1. Enter the	e disease or comp	dications that cause	d the deat							ridge, M	ID 21613 Approximate
			shock, or heart Immediate Cause (F	failure. List only o	one cause on each I	ine.		0-	+	. /		/ /-	-	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a	uth	nose	Ler	ou	e he	ent	ous	ease	
	Examiner				Due to (or as	a conseq	uence on:	. [	1 100	SA	Ven	Nice		
		le le	Sequentially list con-	ditions, nediate	b. Due to (or as	a conseq	uerce of):	ue-1	700	^		Dur	usi	
	ate be executed hysician and the burial-transit	Examiner	Sequentially list con- if any, leading to immoduse. Enter Underli Cause (Disease or in	ying njury		101	ela	N 111	· C · · ·	Dead	-d	icea	<	
	te be executed ysician and ie burial-transit	xal	that initiated events resulting in death) La		C. Due to (or as	a conseq	uence of):		,	-000		17-00		
760,	siciar buri	calE			-									
687	icate phy: s the			_	d									
×	death certifica e attending ph d for use as th	/We	IF FEMALE:		23c. If yes, outcome	of pregna	incv						and Date of	-1
Вох	atter for u	iar	23b. Was decedent in the past 12 n	nonths?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3□	Ectopic p					23d. Date of d Month	Day Year
Ö	the d	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	9□Unknown	it tillie of o	<b>94</b> 111 3 [	1 Ott 161 (s)	ociiy/					
P.0	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th	Ph	Part II. Other signific	ant conditions co	entributing to death t	out not resi	ulting in the u	nderlying o	ause aive	n in Part I		23e. Did tot	pacco use contribute	to the cause of death?
Records,	sign d be	l by	-		•		•	,,	g			1 □ Ye		Probably 4 □Unknown
Ö	w requir been si should	Completed											2 2 2 1 1 0 0 1	
ec	law ast	n jd										24a. Was a autops	v prior te	autopsy findings available completion of cause of
<u> </u>		Sol										perform 1 ☐ Yes 2		os 2□ No
Vital	ding Physician: The law h. After this certificate has t funeral director, page 2 s	Be	25. Was case referre	ed to medical						26. Place	of Death	Check only on	θ/	
of V	hysio this co al dire	၉	1 ☐ Yes 2 ☐	10	Hospital: 1 🗌 Inpati	ent 2 🗆	ER/Outpatien	t 3□ DC	Othe	1 4 July	rsing Hom	e 5 Reside	ence 6 Other (Sp	pecify)
0			27. Manner of Death  1 Natural	5 Pending	28a. Date of Inju	iry iv Year)	28b. Time of Injury	2	28c. Injury Work	at ?	2	8d. Describe ho	w injury occurred	
<u>.</u>	Attending r death. ctor: After by the funer	atic	2 Accident	investigation			, ,	М		'es 2 □ 1	No			
Division	r Atte	‡	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	jury - At ho	ome, farm, str	eet, factor	y, office		2	Bf. Location (St City or Town		Rural Route Number,
	saft saft al Di ed in	G			,	(=,)	,						, στατογ	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	Medical Certification;	29a. Certifier (Check only	Certifying Phy	sician: To the best	of my kno	wledge, death	occurred	at the tim	e, date an	d place, a	nd due to the ca	ause(s) and manner ate and place, and d	as stated.
	the H in 24 the F splete	edi	One)	11	and manner st	ated.		restigation	. птину ор	illion, dea	ui occuire	C at the time, Q	ate and place, and d	de to the cause(s)
	To To	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month									ath, Day, Year)			
	(	Douglas Helmanno Dlockell 04/04/									19			
	10		30. Name and adde	ss of person who c	ompleted cause of	death (Item	23a) (Type,	Print)					- · · · · · · · · · · · · · · · · · · ·	ay 21617
	Ø		Double	5 Hornie		25	to CEA	TRE	VELL	ER	OAD	CENT	REVILLE	ms 21617
3	Sta		31. Date filed (Month		32. Registr	rar's Signa	ture	-	/					
	Registr	ar		ALM TO 5		Sec.	A. A	The same						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jessica Marie Cole State of Maryland / Department of Health and Mental Hygiene 2009 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 12, 2009 1610 hrs **Medical Examiner** Jessica Marie Cole 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Prince George's Hagerstown Hall, Room 4131 College Park If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Foreign Months Davs Director 1988 Country) Illinois 20 Sept. 12, 324-82-5957 Yrs M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Cambridge 1 X Yes 2 No Dorchester , or items 23a or 28a-f show r must be notified at once. MD death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21613 101 Canvasback Wav Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 2 X No Yes bi-racial Specify: f Yes. Give Year Yes 2 X No specify: after Widowed 1 Divorced If item 27 is marked other than "natural", her traumatic event, the Medical Examiner \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) college student MD 21215-0036 12 1 ment of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Johnson Richard L. Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 101 Canvasback Way, Cambridge, MD 21613 father Richard L. Cole 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) X Burial 2 Cremation 3 Removal from State 4/17/09 tant: Dorchester Mem. Park Cambridge, MD Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Cambridge.  $_{\rm MD}$ 700 Locust St Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Medical Death a. Hanging Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician at use as the burial -AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live hirth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death Other (Specify) signed by the atte Yes 2 No 9 Unknown g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, page 2 should nee( 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? No ✓ Yes 2 ~ 2 the Hospital or Attending Physician: in 24 hours after death. funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) æ examiner? Other: Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this ပ 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) FOUND: After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred . Manner of Death Certification: Subject hanged self FOLIND: Natural Yes 2 ✔ No Pending To the Funeral Director: completely filled in by the Apr 12, 2009 1603 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) Domitory:Hagerstown Hall,Room 4131, College Park, M determined (Specify) Dormitory Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number April 13, 2009 O.C.M.E

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Laron Locke MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registrar

DHMH 17 Rev 1/2001

State

SOCITY AINICION SUITE B SALICAMA, MAZIRO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

SVETLANA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23, April 2009 3:45A M Shirley Μ. Cole /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Months Hours 1 🗆 M 2 🖾 F oct.8,1935 Maryland **Director** 219-34-7575 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar in sist by mothed at 1 XYes 2 No Director PG MD Bladensburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5802 Annapolis Road United States 20710 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 No Specify. \$ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Private Housewife 10 alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtis Marshall ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6800 Fort Bock Road Washington, MD. 20744 Health a Timothy Cole/son other t permit, Pages 1 an Department of Heal Important: If Item 2 any Injury or other: altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 5/1/09_ Landover, MD. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License oanna 3910 Silver Hill Rd., Suitland, MD. 20746 Approximate Interval Between Onset and Death 23a. Par 1 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Septicemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anorexic Encephalopathy Sequentially list conditions, if any leading 1. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed Acute Coronary Syndrome burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 D Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a Was an certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. Il Director: After i d in by the funera 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Hospita

Signature

Dr., Chererly, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geome

onald

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State AMEND #10c Per FH/FCHD 4/15/09emicicate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** DiToto Nicholas 14, 2:57 A. M Edward April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 60 Nov 5,1948 218**-**54-5584 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County fshow 10d. Inside City Limits if than "natural", or items 23a or 28a-f sho Frederick Maryland Frederick -Federick-Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2520 Waterside Drive Unit 112 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1968-70 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Information Resource Officer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DiToto Madeline Edward Ernest Cecilia DeFilippo ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linnet Jordan/ Niece 9012 Bealls Farm Road, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Resthaven Mem. Gards 4/22/2009 Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA Japan WM DOO 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner End Stage Liver Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9 I Unknown 9 Unknown Hospital or Attending Physician; The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' certificate 1∐Yes 2k∏No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director; At completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00067210

Box 68760

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Division of Vital Records,

State

APR 15 2009 Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

R. Khirbat 400 W. Seventh Street, Frederick, MD 21701 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14 (0

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year $\mathbb{P}^{\mathsf{M}}$ BRADLEY DURST 6:49 APRIL 10 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL FREDERICK FREDERICK HOSPITAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1 XM 2 ☐ F 49 Yrs. 212-64-9894 Feb. 17, 1960 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8506 Guertin Court 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 ☐ Widowed 4 🔯 Divorced 16b. Kind of Business/Industry Frederick County 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Substitute Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Durst Joanne Siehler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Durst ' Father 12008 Piney Glen Ln. Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State April 13, Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature of Junial Service Li Name and Address of Facility Sthaven Funeral Services, Skkot Cody P.A. 21701 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate ause (Final implications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest. Approximate Interval Between one cause on such line Onset and Death disease or condition resulting in death) Due to ( as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28d. Describe how injury occurred

law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, signed by the a P.O. of Vital Records,

Examiner Physician/Medical 2 icate has been si , page 2 should t Completed certificate has Be Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ō items 23a

Pages 1 and 2 should be filed within 72 hours after death a nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23, my or other traumatic event, In. Medical Exam in crust

Department of Health Important: If item 27 any injury or other troope.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

in ust be notified at

Director

Funeral

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Completed

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with the Maryland

5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifiei

Medical

State

Registrar

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated 29b. Signature and title of

29c. License number

Name and address of person who

31. Date filed (Month, Day, 15

DHMH 17 Rev 1/2001

or Attending Division

To the Hospital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year April 15, Alma Dixon Dirlik 0720 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year Mar 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □XF 257-32-4657 85 1924 Georgia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Arlington Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2616 S. Uhle Street 22206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. White Specify: 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Dixon Mary Ida Rowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven P. Dirlik/son 10219 Day Avenue Silver Spring, MD 20910 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State W. Arundel Crematory 04/17/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signature of Funeral Service Lic Gaing Monte Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure disease or condition resulting in death) Due to (or as a consequence of): Metastatic Bladder Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Urinary Tract Infection Due to (or as a consequence of) Hypernatremia IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 □No 1 □Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

Examiner

Director

Funeral

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Completed

Be

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VA

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Mardical Exercises.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

/Medical

Examine burial-trar Physician/Medical 2 Completed director Be Certification: To funeral

1 ☐ Yes 2 💢 No

27, Manner of Death

1 X Natural

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month)

3 Suicide

29a. Certifier

law requires that the death certificate be executed attending physician for use as the buria signed by the a icate has been signated by page 2 should b The certificate this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After

3 E.G.

29b. Signature and title of certifis

5 Pending

investigation

6 Could not be determined

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D67279

April 16, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

Suganthi Alagarsamy, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910

1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

State Registrar

Medical

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eva H. Ehrlich 2009 April 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5802 Nicholson Lane #604 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 84 June 6, Director 094-24-3913 1924 Hungary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f sho event, the Assign Evaning runt or notified a Director MD Montgomery 1 √Yes 2 □ No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 5802 Nicholson Lane #604 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☑No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Dr. Ferencz Hevesi Magda Rottenstein traumatic ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Bernard Ehrlich - Husband 5802 Nicholson Lane #604 Rockville MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Lebanon 4/17/09 Adelphi, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure 1 Month disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Mitral Valve Insufficiency 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown ρ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760, P.O. Records, The Division of Vital

Maryland 21215-0036

Baltimore,

the Hospital or Attending Physician: death. within 24 hours after death To the Funeral Director: filled in by the 2

State

ca

Medi

Registrar

29b. Signature and ifier 29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MD D33554

4/14/09

30. Name and address of person who e of death (Item 23a) (Type, Print) ed caus 541a Yerg MD

Connecticut Ave. NW #117 Washington DC 20015

31. Date filed (Month, Day, Year) 16

4 Homicide

(Check only

29a, Certifier

John

one)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 009 The 1ma Inez Foss 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Plate La 105 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Hrs. 8. Date of Birth (Month, Day, Year) September 6,1922 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours 224-24-0037 86 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4526 Phillips Road 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Supervisor DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Frank Maude Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Baker/Daughter in law 4520 Phillips Road, La Plata, MD 20646 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Brownsville Church Cem. 4/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Brownsville, Maryland 21. Signature of Funeral Service Licensee ²ARTHART dechous funeral home, P.A. M00945 Havil Elle. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is merked other than ury or other traumatic event, Ire M

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny Injury or other trau once.

**Funeral Director** 

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Completed

Be

2

filed within 72 hours after death with the Maryla d other than "natural", or items 23a or 28a-f sho event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

Examine Physician/Medical \$ Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

•	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 20□ Mo 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying c	ause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
410.				24a. Was an autopsy performed? 1 □ Yes 2 € 1	
25. Was case referred to medical examiner?			26. Place of Dea	th Check only one)	
1 Yes 2 No.	Hospital: 1 Purpatient 2	ER/Outpatient 3 ☐ DC	OA Other: 4 Nursing H	ome 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1  Natural  2 □ Accident  investigation	28a. Date of Injury (Month, Day, Year) on	28b. Time of 8 2 Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ome, farm, street, factory	, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
29a. Certifier (Check only 2 Medical Exa	Physician: To the best of my kn	owledge, death occurred ation and/or investigation	at the time, date and place	e, and due to the cause	(s) and manner as stated.

State Registrar

Medical

29b. Signature and title of certifier

46046

29c. License number

29d. Date signed (Month, Day, Year)

Pees-21-4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIR M ALIKHANI aPLATA, MD 20646

and manner stated

			For	State of	Marylar	nd / Depa	artme	nt of H	ealth ar	nd Me	ental Hy	giene	Э	
			State Registrar			Cei	rtifica	te of L	Death			Reg. No	2009	1390
0	Physici		1. Decedent's Name (First, Middle, Las	st)							2. Date of De	eath Da	y Year	3. Time of Death
e distrib	/Medic		Gertrude	Eve	lyn		F	orema	an		4	13	2009	3:45 AM
سر	Examin	er	4a. Facility Name (If not institution, give	street and nun	nber)		4b. City	, Town, or	Location of	Death		40	. County of Deat	h
400		la .	Harrison Sr. Livin					w Hil		4 Uro			Worceste	
83	Funeral		5. Social Security Number 6. S	9X □M 2 <b>X</b> F	7. Age (In yrs.		Months	Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da	ay, Year,	9. Birt Co	hplace (State or Foreign untry)
	Director		214-32-1621 Usual Residence of Decedent		98	1101					6 <b>-</b> 10-1	9.10	New	York
	rland ow at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary fied	ţ	MD Worcest	er		Snow Hi	11							1 ☐Yes 2X No
	r 28a	Director	10e. Street and Number			JIIOW III		ip Code				10g. Ci	tizen of What Co	untry?
	h wit	a D	430 W. Market Str	eet				2186	53				USA	
	deat	Funeral	11. Marital Status	12. Was Dece Armed For		.S. 13.	Was Dece	edent of Hi		in? (Spec	cify Yes or No	)-	14. Race - Ame Black, White	rican Indian,
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	/Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2X No		1		Specify:	T delto I	ilouri, oto.			White
8	ural",	d by	3 V Widowed 4 □ Divorced	Year or Da	ites:									
7	"natı	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	kind of w	ual Occupa ork done d	ation <i>luring most d</i> )	of working	g	16b. K 	(ind of Business/	ndustry
7	withir ene. than	μ	Elementary/Secondary (0-12)	College (1	-4or 5+)				,			0-	m II.ama	
2	filed Hygid ther ant, tl	ပ္သ	17. Father's Name (First, Middle, Last)			<u> </u>	omem	aker	18. Mother's	s Name	(First, Middle	-	vn Home	
au	d be ental ced o	To Be	Luther	Levv		Gooda	1.						,	0.177
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (					_	Minni and Number			Mae er, City	or Town, State, Z	Gill Tip Code)
Š	alth a 27 is 27 is ar train		P. Maxine McCread	v - Daus	⊇hter								rvland	
e,	of He		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	ame of	i	Da			ocation - City or	
Ĕ	Page nent int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		state	inghil	-	•	· i	4-16-	-2009	Не	bron, Ma	ervland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	see	1 1				s of Facility				al Home	rr y rand
<u>m</u>	9 9 E E 9			y D	ppe-	7	05 E	. Mai	n Stre	eet,	Salis	bury		and 21804
			23a. Pa v . Enter the disease, or com shock, or heart failure. List only	ations that cannot cause on ea	aused the deat ach line.	th. Do not ent	er the mo	de of dying	g, such as ca	ardiac or	respiratory a	arrest,		Approximate Interval Between
	Physician	2. 5	Immediate Cause (Final disease or condition	A	LZHEIN		1	MEN					C)	Onset and Death
OF STREET	/Medical		resulting in death)	***	or as a consec						<del></del>			
ß	Examiner		Sequentially list conditions.	0	AILUR	- Aur	0	THRI	XE					
	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conseq	juence of):								
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8760,	icate be executed physician and s the burial-transit			Duc to (	71 d3 d 001130q	jucilios orj.								
387	phys the	dical	•	d										
×	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outo	come pf pregna	ancy							23d. Date of deli	NOD!
. Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo	1 □Live bi 4□Pregna	irth 2 ☐ Feta ant at time of c	al death 3	Ectopic   Other (s	oregnancy specify)	_				Month Month	Day Year
o.	the o	Jysi	9 ☐ Unknown	9□ Unkno	wn									
Vital Records, P.	w requires that the de been signed by the should be detached	by Pł	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
ğ	quire en sig uíd bu										1 🗆	Yes 2	Mo 3□ Pro	obably 4 □Unknown
ပ္က	aw re	Completed									24a. Was		24b. Were au	topsy findings available
ž	The lav	mo									auto perfo 1 Yes	psy ormed? 2	death?	ompletion of cause of 2 No
ā	ysician; The is certificate hadirector, page	Be C	25. Was case referred to medical						26. Place o	of Death	(Check only		) I les	220110
>	nysic nis ce direc	일	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Ir	npatient 2	ER/Outpatier	it 3□ D	OA Othe	er: 4 Nurs	sing Hom	e 5□Resi	idence	6 □Other (Spec	ify)
0	ng Pl		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of (Monti	of Injury h, Day Year)	28b. Time of Injury	f	28c. Injury Work			3d. Describe			
Sio	endile eath. or: A the fu	atic	2 ☐ Accident investigation				М	1 🗆 \	Yes 2 □ No	0				
Division or	or Att ter de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zoe. Flace	of injury - At h ng, etc. (Specii	ome, farm, str fy)	eet, facto	ry, office		28	3f. Location ( City or To	Street ar wn, State	nd Number or Ru e)	ral Route Number,
	oital ours af		00 0 415 - 470 414 - 11	-1-1 T -11										
	Hos 24 ho Fune stely f	Medical	29a. Certifier 1 Certifying Ph	niner: On the ba	isis of examina	owiedge, deati ation and/or in	vestigatio	n, in my o	ne, date and pinion, death	place, ai	nd due to the d at the time,	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Mec	29b. Signature and title of certifier	and mann	er sidieu.		29	c. License	number			29d. Da	ite signed (Month	ı. Dav. Year)
	F≯Fŏ (		<b>\</b>	typul	MI)			-	6217	2			-14 - 20	
	100		30. Name and address of person who	completed cause	of death /Iton	n 23a\ /Tune	D. Jah		_					
	20		SHARAD R S		M.I)	1604 N ature	PARK	G 57	- Por	omo	KE G	TY	MD 21	851
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	strar's Signa	ature &	1	, ,	1 00			*		
	Registr	ar	APR 15	2009 🔏	Eneur	1. 1	park							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Per FH G89812/01/09 JH
State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14, Day **Physician** 2009 Year Howard Gross 9:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 011-16-23118 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F 07/21/1919 Director 89 Pennsylvania Usual Residence of Decedent sa or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with the and Mental Hygiene. ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n 2904 N. Leisure World Blvd. 20906 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc orces: 2□No WWII 1 ∏Yes 2 ☐ If Xes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Navy Personnel Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked of J. Fred Gross Jolivette 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Gross Son 14040 Great North Terrace-Gaithersburg, MD. 20878 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Marks Episcopal 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD. 2009 Church Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License DeVol Funeral Home 10 E. Deer Park Drive - Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atrial Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed and Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year P.O. signed by the a d be detached f The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Osteoporosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Benign Prostatic Hypertrophy has autopsy page performed? certificate 1□ Yes 2√D No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation 1 X Natural 124 hours after death.

Ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0019609 April 15, 2009 30. Name and address of person who completed cause of death (Item 234) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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Raman R. 31. Date filed (Month, Day, Year)

32 Registrar's Signature

MD - 10810 Darnestown Road, Ste. 202 - Gaithersburg, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** 6:20P M Stephen J. Gray April 13, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lorien Mount Airy Mount Airy Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Min. Days Hours 42 182-42-2307 Director 27, 1966 Pennsylvania Dec. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventina is ust be natified at any Injury or other traumatic event, the Medical Eventina is ust be natified at any once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes X□No Funeral Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9504 Greenel Road 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by If Yes, Give Year or Dates: Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None - Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Gray Ann Brandt ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann B. Gray - Mother 9504 Greenel Road, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematorium 4/15/09 Alexandria, Virginia 4 ☐ Doription 5 ☐ Other (Specify) 21. Signature of Funer I Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home *ح*لا 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia 3months disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t irector, page 2 sl autopsy performed? Yes 20 No death's 1 ☐Yes 2 ☐ No 1 ☐ Yes this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ono

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Day

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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00059423

Surta 150-236 Clarksville MD

April 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year (m 00) 1:15 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 575 Laurel Road Riva Anne Arundel 5. Social Security Number If Under 1 Year Months Days **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/22/1944 Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Months 214-42-7005 Hours Director 65 Texas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be redified at agine. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Anne Arundel Riva 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 575 Laurel Road 21140 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1966~72 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vears Professional Fund Raiser Direct Mail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Raymond J. Grace, Jr. Mary Helen Patterson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie A. Grace/ Wife 575 Laurel Road, Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/15/09 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furieral Service Licensee Malos Wille 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** na /Medical Due to (or as a consequente of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical certificate has been signed by the attending prector, page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \( \sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Maridence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 🗆 Yes 2 □No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature le of certifier and ti 29c. License number 29d. Date signed (Month, Day, Year) 062772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (20 Sute 300 Amples MO 21401

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			. For	State of Maryla							egible.	10005
			State Registrar		Ce	rtificate	e of Dea	th	Reg	g. No	009	13905
	Physic	ian	1. Decedent's Name (First, Middle, Last						Date of Death     Month	Day	Year	3. Time of Death
	/Medi		Rowena J. Gla			1			April 1		2009	12:40 P ^M
7	Examir	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or Locati				ounty of Death	
90 g 8	Funoval	45)	Larkin Chase Nurs  5. Social Security Number 6. Se		s. last birthday)	If Under	Bowie	der 24 Hrs.	8 Date of Birth		ince Ge	
436.	Funeral Director			□M 2 <b>X</b> F 89	Yrs.	Months	Days Hou		8. Date of Birth (Month, Day, ) 5/19/19	19	Penn	place (State or Foreign ntry) sylvania
	tiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow int, the Medical Examinar must be notified at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	B-f e	ctor	Maryland Prince G	eorge's I	Bowie							1 ∏ Yes 2 🗍 No
	or 28	Director	10e. Street and Number			10f. Zip	Code		10	g. Citize	n of What Cou	ntry?
	ath w	ra.	16010 Excalibur Rd.	, #D312		20	0716				USA	
	er de	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Deced If Yes, spec	ent of Hispanic ify Cuban, Mexi	Origin? (Spe ican, Puerto I	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 □Yes 2 X No If Yes, Give Year or Dates:		1 🗆 Yes 2	No Spec	cify:		S	pecify:	• •
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21	be filed within 72 hours after death with the Marylan tal Hygiene od other than "natural", or flems 23a or 28a-f ehow other than "natural", or flems 23a or 28a-f ehow event, the Macital Experience count to notified at	Completed	11th		Н	omemal	ker				Home	
nd		Be	17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle, Ma	aiden Su	ımame)	
yla	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	၉		Weaver					Walters			
Maryland	S S S		19a. Informant's Name/Relationship (T)						Route Number, (			
	other tra		Jeanne M. Watts/D		Place of Dispo	St.St	tephens					, MD 21032
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ F	terrioval from State	Place of Dispo						tion - City or To	
喜	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signal of Funeral Service Jacons		D Veter				orge P.	Lnel	tenham,	Maryland
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	Physician		Immediate Cause (Final	A A	V	1	. 1.11	. Ci o	1		4	Interval Between Onset and Death
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2" -	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conse	quence of):	•	-		., 3			1
	and and I-tran	хаш	that initiated events resulting in death) Last	Due to for as a conse	10/1							04/5
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687	# × 9		~ (	. J. Z. N	1001	101						713
Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn						23d	I. Date of delive	20/
m.	death e atte	cla	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of		Ectopic pre Other (spe				250	Month	Day Year
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Ś	99 es	by F	Part II. Other significant conditions cor	itributing to death but not re-	sulting in the ur	nderlying ca	use given in Pa	rt I.	23e. Did tobac	cco use	contribute to the	ne cause of death?
ord	w requir been si should	ted							1 🗌 Yes	2 <b>2</b> N	lo 3 Prob	ably 4 Unknown
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	Page Th	Sol							performe	d? No	death?	2 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	lospital:			1 00	/	Check only one)			
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Division	Attending r death. sctor: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	lome, farm, stre				Bf. Location (Stree	et and N	umber or Rura	/ Route Number
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	To the Hospital or Attanding R within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	sician: To the best of my known of the basis of examination and pranner stated.	owledge, death ation and/or inv	occurred at estigation, i	t the time, date n my opinion, d	and place, ar leath occurre	nd due to the caus d at the time, date	se(s) and and pla	d manner as st ice, and due to	ated. the cause(s)
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,	2 may	١	N Tu	~ \			3419	イノダ		4.	-17-	2007
7	3/10		30. Name and address of person who co	moleted cause of death (iter	m 23a) (Type, f	Print)	11.	11.	DIA	2	Da	JR MA
			31 Date filed (Month Car Vers	Jana Koli	7000	ni	16,11	JIIL	16 d	51 4	- 1300	22716
3.5	Sta Registra		31. Date filed (Month, Day, Year) APR 15 20	32. Registrar's Signa	ature.	ares	•					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Alan Thomas Gravenor April 11, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 516 Emory Court, apt. 101 Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign
Country) 1**X** M 2∏ F Months Days Hours 212-78-3842 Director 48 11/01/1960 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal ment by nother traumatic 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Emory Court, Apt. 101 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify. 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk retail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edgar Thomas Gravenor Virginia Gertrude Perdue ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia G. Gravenor/mother 516 Emory Ct., Apt. 101, Salisbury, MD 21804 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 4 ☐ Donation 5 ☐ Other (Specify) 4/16/09 Hebron, MD Gardens Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 cute Myocardia Unknows /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Se uentially list addition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed rabeter attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2☐No 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 XYes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an 1 □Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\superstruct{\substraction}{\substraction}\) Nursing Home 1 XYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) )QN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8/m Nino 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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			1 - For State Registrar	State of Maryla		artment of I <i>rtificate of</i>			giene Reg. No. 2	009	13907
	Physici		1. Decedent's Name <i>(First, Middle, Las</i> <b>Lillian Horowitz</b>	it)				2. Date of De			3. Time of Death 6:00p M
-	/Medio Examir		4a. Facility Name (If not institution, give	,			or Location of Death	-	4c. Coun	nty of Death	
H	Funeral Director		Renaissance Gardens a 5. Social Security Number 6. So 077-16-1352 11		age . la <i>st birthday)</i> 90 Yrs.	Silver : If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da January		9. Birthp Coun	place (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge		ity, Town or Lo <b>Gre</b>	enbelt				10	0d. Inside City Limits
	h with the h	al Director	10e. Street and Number 2E Northway			10f. Zip Code	0770		10g. Citizen o		itry?
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanterings by notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □Yes 2 🛣 No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Ra Bl	ace - Americ lack, White, e sify: Wh:	
Baltimore, Maryland 21215-0036	within 72 ho jiene. r than "natu r . Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ade completed) (Giv		edent's Usual Occupation e kind of work done during most of working DO NOT use retired) istrative Assistant			16b. Kind of Med:	Business/Ind	fustry
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timore	permit. Pages 1 Department of H Important: If itel any injury or ott		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 XX  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	n Haven l	sition (Name of natory or other place Memorial Pa	ark April	Date 17, 2009	20c. Location Winter	Park, I	
g	Depa Impo any in	4 9	21. Signature 1 June al Service Licens	1/20	-	500 Univer	. Collins Fi rsity Blvd.	West, Si	lver Spr	ing, MD	20901
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	attendin for use	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ o 9 □ Unknown	23c. If yes, outcome of pregn  1  Live birth 2 Fete 4  Pregnant at time of one of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	al death 3	Ectopic pregnance Other (specify)	sy			eate of deliver	ery Day Year
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SION	tending Feath.  or: After the funera	Certification:	27. Manner of Death  1 ★ Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl M 1 □	ryat k? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
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	3		29b. Signature and title of certifier	recunf	)	29c. Licens	15734	12	29d. Date signe	15/	/09
			30. Name and address of person who co		Kd	Silve		np	ND a	2090	24
	Stat Registra	~	APR 16 2009	22. Registrar's Signa	par	1	,	V			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year 5, VICTORIA HELEN HAWKINS APRIL 0230 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Montgomery General Hospital Olney MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 26, 1931 9. Birthplace (State or Foreign Country) Maryland Months Days Hours Min 1 □ M 2 🕱 F 213-30-1290 78 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Rockville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 N. Horners Lane 20850 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Elementary/Secondary (0-12) College (1-4or 5+) Clerk yr Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel O. Hawkins Lula C. Booze 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Payne (Daughter) 4002 Wood Swallow Ct, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dongton 5 □ Other (Specify) Rockville, MD mcoln Park Cem 4/11/09 21. Sign thir of Funeral Service Licensee 2. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. leads 6246 N. Washington St, Rockville, MD 20850 23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. onot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final granas disease or condition resulting in death) mo Due to (or as a consequence of): Rena Due to (or as a consequence of) to Pi Orlina Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one)

Physician /Medical Examiner

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attending physician for use as the buria

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page 2 should

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P.O. Box 68760.

Division of Vital Records,

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Physician/Medical

Completed

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Certification:

Medical

State Registrar

Department of Important: If it any injury or conce.

**Physician** 

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. In the filem 27 is marked other than "natural", or ite mry or other thaumatic event, the Medical Exercite Iny or other thaumatic event, the Medical Exercite.

Baltimore, Maryland 21215-0036

Director

Funeral

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death with the Maryland

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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

9 Unknown

1 Inpatient

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29a, Certifier

29c. License number D0068026 29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padmaja Bandi, 31. Date filed (Month, Day, Year)

18101 Prince Philip Dr., Olney, M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Richard Olan Harrison April 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation a Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Schisbury If Under 1 Year If Under 24 Hrs. Wicomico 8. Date of Birth (Month, Day, Y Mar. 25, Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Year. 83 218-16-9314 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits Unknown 1 Liyes 2 No Unknown Unknown Unknown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Unknown Unknown 12. Was Decedent Ever in U.S. Armed Forces? 1943- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1947 1 □Yes 2 🛣 No Specify 3 Widowed 4 X Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Dept. Supervisor Poultry Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olan William Harrison Anna Pauline Berryman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Adkins/Sister 504 Edgewater Drive, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation MD Veterans Cemetery 4/16/2009 4 Donation 5 Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modal Experience results by rutilised anone.

Baltimore, Maryland 21215-0036

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has been signed by 2 should be deta within 24 hours and 7. To the Funeral Director: Aft

To the Hospital or Attending Physiclan: The law requires that the deat | certificate be executed Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	a. Com	Cana	7			Onset and Dea	en ath
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a co	Juence of).	Surfin	Ru Boron	er A	inz.	50
ysicialiyine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1  Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 🗆 Ectopi	c pregnancy (specify)		23d. Date of del Month	ivery Day Yea	ar
pieted by Pr	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of dea	
				·	24a. Was an autopsy performed' 1 □ Yes 2 ⊡	prior to death?	topsy findings ava completion of caus 2 □No	ailable se of
2	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
	1 Yes 2 □ Ho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	cify)	
illoadin.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	iral Route Numbe	ır,
- Calcal	29a. Certifier (Check only one) 1 ∠ frying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated,	owledge, death occum ation and/or investigati	ed at the time, date and plac on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)	
M	29b. Signature and title of certifier	Ma	2	29c. License number	29d.	Date signed (Monti	n, Day, Year)	

Registrar

200 C

We. Salisburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins.

31. Date filed (Month, Day, Year)

			For State	State of	Marylan			Health and M	Mental Hy	giene	0 10010
			Registrar  1. Decedent's Name (First, Midd	lle, Last)		Cei	rtificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physici /Medic		Jean Kelly Hi						APRIL	- 2 a	°9 a:00 PM
>	Examin	er	4a. Facility Name (If not institution CIVI STAM)	ed ICA	LCEN	ITER	4b. City, Town, o	PLAT	A	4c. County of E	PLES
	Funeral Director		5. Social Security Number <b>577–34–1122</b>	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs <b>82</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da November	11,1926	Birthplace (State or Foreign Country) Washington, DC
pue	2 2		Usual Residence of Decedent  10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary	a-f sho	ctor	Maryland St.	Mary's	Med	chanic	sville				1 □Yes 2 📉 No
with the	Sa or 28	I Dire	10e. Street and Number 35445 Golf Cour	se Drive			10f. Zip Code	0659		10g. Citizen of What	t Country?
5-0036 72 hours after death with the Marvland	points. Tages it and a Should be men within a Libour and beautiful the library and population in the library and health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanning must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	ces? 2 ANo e	- 1	Mas Decedent of H fYes, specify Cub l □Yes 2 MAN	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Dican, etc.)	- 14. Race - A Black, W Specify:	American Indian, /hite, etc. <b>White</b>
15-0	"natur	letec	15. Decede (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	pation during most of work d)	king	16b. Kind of Busine	ess/Industry
21215-0036	giene.	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		naker	u)		At Home	
and	ental Hy ked othe c event,	To Be C	17. Father's Name (First, Middle William Kelly	, Last)					ne (First, Middle, <b>J. Morr</b> i	Maiden Surname) <b>İS</b>	
Maryland	alth and M 27 is mar r traumat	-	19a. Informant's Name/Relation Joseph B. Hill,		ınd	19b. Mailir <b>35445</b>	ng Address (Street Golf Cou	and Number or Ru urse Rd.,	ral Route Numbe <b>Mechan</b> i	er, City or Town, Sta icsville,	te, Zip Code) MD 20659
Baltimoré,	art of Heart If Item		20a. Method of Disposition  1 ☐ Burial 2 ★Cremation  4 ☐ Donation 5 ☐ Other (3)		toto C	emetery, crer	sition (Name of natory or other place d-Echols	ce) Ap	ril 27,	20c. Location - City  Charlott	- п-11 м
Balti	Departm Importar any inju		21. Signatur, of Funeral Service		M008	17	2. Name and Addre 30195 <b>Th</b> 1	ess of Facility <b>Br1</b>	nsfield- Rd., Cl	-Echols F. narlotte F	те нагг, мо .Н., Р.А., Hall, MD 20622
			23a. Part1. Enter the disease, of shock, or heart failure. Lis			h. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ct	H.						Onset and Death
	xaminer		Constantially that are dilitions	b Re	or as a consequence	yence of):					=3WK 5
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	orlas a consequ	uence of):					= 3WK 5
<b>O</b> ,	physician and the bunal-transit	Exar	that initiated events resulting in death) Last	C Due to (c	or as a consequ	uence of):					
38760, icate be ex	physic s the bu	dical		d							
I Records, P.O. Box 68760, The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2□Feta ant at time of c	I death 3	: ] Ectopic pregnand ] Other (specify) _	су		23d. Date of Month	f delivery Day Year
S, P.	igned b	by Pt	Part II. Other significant condit	ions contributing to de	ath but not resi	ulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?
ord	been s	eted	101	10000	0 P C				1 🗆 \		Probably 40 Unknown
Reg	te has age 2 s	Completed	(72	orneo (	0'-				24a. Was autop perfo	osy prior deat	e autopsy findings available r to completion of cause of th? Yes 2 □ No
Vital	sertifica ector, p	BeC	25. Was case referred to medica examiner?		,			26. Place of Dea			165 2 1140
of of	er this eral dir	<u>ان</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a Date o	npatient 2	28b. Time o	28c. Inju	ry at		dence 6 Other (	Specify)
Division of Vital Records,	eath. or: Afte the fun	catio	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	tigation	h, Day, Year)	Injury		rk? ]Yes 2 □ No			
Divi	rs after d ral Direct led in by	Certification:	4 ☐ Homicide determ	mined 286. Place of buildin	ig, etc. (Specif	y) 	eet, factory, office		City or Tov	vn, State)	r Rural Route Number,
Division of Vita	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certify  (Check only one) 2 ☐ Medica	ing Physician: To the I Examiner: On the ba and mann	isis of examina	wiedge, deat ition and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
٥	vithin To the comple	M	29b. Signature and title of certific	or ()	MO		D O	o627	73	29d. Date signed (M	fonth, Day, Year)
4	M		30. Name and address of person	who completed cause	of death (Iten	23a) (Type,	Print)	- ANE	LAGA	TA MD	20646
	Sta		31. Date filed (Month, Day, Year	32.436	egistrar's Signa	ture		114		1. 120	.54 14
DHMF	Registr 		APR 24	CLAUS /CER	and p	9. fg					1,514,514
						OR	GINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month April 2009 6:18 PM Welford Dale Hudson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 X M 2 □ F Months Hours 304-14-0903 89 Sept. 19,1919 Indiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Maryland Maryland Frederick Thurmont 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11113 Hessong Bridge Road 21788 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Superintendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Hudson Beatrice Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia E. Hudson 11113 Hessong Bridge Road Thurmont, Maryland 21788 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 4 ☐ Donation 5 ☐ Other (Specify) 14, 2009 Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. Dist only one cause on each light Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown

**Physician** /Medical Examiner

> transi and

attending physician a

sate has **bee**n signed by the atte page 2 should be detached for i

**Director:** After this certific

filled in by

I or Attending Fafter death.

within 24 hours a

To the Funeral L Hospital

law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it et l'edicat Examiner must be routhed at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter

item 27 i

Department of Important: If it any Injury or o

Pages 1

Baltimore, Maryland 21215-0036

death with

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Completed

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Examiner Physician/Medical

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Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 1 □Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes No Other: 4 \( \sum \) Nursing Home Hospital: 2 ER/Outpatient 3 DOA Inpatient

mpleted cause of death (Item 23a) (Type, Print)

28b. Time of 28c. Injury at Work?

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes No

27. Manner of Death Date of Injury (Month, Day, Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

 Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

23e. Did tobacco use contribute to the cause of death?

(Check only one) and manner stated. 29b. Signature and title of certifie

State Registrar 32. Registrar's Signature

29a. Certifier

30. Name and address @

DHMH 17 Rev 1/2001

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Reg. No. 2	0	0	9		39		
- 41				-	TT	. 41	

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanines must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar	Cert	tificate of Dea	th	Reg	.No.2009	13912		
	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death				
an al	Winfield Alexander Hicks				April	^{Day} 200	9 6:05 A M		
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati	ion of Death		4c. County of Dea			
	211 Riverside Road		Edgewater	nder 24 Hrs.	0.0.1(0):11	Anne Ari			
	1.₩ 2 □ E	n yrs. last birthday) Yrs.	Months Days Hou		8. Date of Birth (Month, Day, Y	ear) C	thplace (State or Foreign ountry)		
	Usual Residence of Decedent	88 113.			11/23/1	920 Virg	ginia		
		c. City, Town or Loca	ation				10d. Inside City Limits		
ğ	Maryland Anne Arundel	Edgewater					1 □ Yes 2 😿 No		
irec	10e. Street and Number		10f. Zip Code	. Citizen of What C	ountry?				
a D	211 Riverside Road		21037			United St	tates		
ner	11. Marital Status 12. Was Decedent Ever	r in U.S. 13. W	as Decedent of Hispanic Yes, specify Cuban, Me	c Origin? (Spe	cify Yes or No-	14. Race - Am Black, Whit			
F	1 Never Married 2 Married 1 Vives 2 No	1010	□Yes 2 🛣 No Spe		110411, 010.7		hite		
q p	3 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working									
Maryland   Anne Arundel   Edgewater   10e. Street and Number   211 Riverside Road   10f. Zip Code   21037   United Sta   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta   21037   United Sta									
2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street and Nu			City or Town, State,	Zip Code)		
	Nancy Lee Ward/daughter	1 Dai	sies Circle	e. Edge	water, M	D 21037			
	20a. Method of Disposition	20b. Place of Dispos cemetery, crema	ition (Name of	Di	ate 20	c. Location - City or	Town, State		
,	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Kalas Cr		4/14	4/2009 F	Edgewater	MD		
	21. Signature of Juneral Service Licensee		Name and Address of F			Calas Fund			
	1/2 / Colouls	29	73 Solomons	Island	d Rd., Ed	lgewater,	MD 21037		
	3a. Parti Enter the disease, or complications that caused the	death. Do not ente	r the mode of dying, suc	h as cardiac o	r respiratory arres	t,	Approximate Interval Between		
	Immediate Cause (Final disease or condition	Nevin	ONIA				Onset and Death		
	resulting in death)  Due to (or as a co								
	Sequentially list conditions b.	COPD.					10 yRS		
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	onsequence of):							
Kam	Cause (Disease or injury that initiated events c	ansaguanas of):							
E E	Due to (of as a co	msequence on.							
Medical Examiner	d								
	IF FEMALE: 23c. If yes, outcome of p	pregnancy				23d. Date of de	alivery		
ciar	in the past 12 months?	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			Month	Day Year		
Be Completed by Physician/	1  Yes 2  No 4  Pregnant at tirr 9  Unknown 9  Unknown								
y P	Part II. Other significant conditions contributing to death but n	ot resulting in the und	derlying cause given in P	Part I.	23e. Did toba	cco use contribute t	o the cause of death?		
d b	MeTASTATIL PR	057177	= CAN	ILER	1 Yes	2 □ No 3 □ F	robably 4 🔲 Unknown		
olete					24a. Was an	24b. Were a	utopsy findings available		
E O					autopsy performe	d?₄   death?	completion of cause of s 2 □ No		
Se C	25. Was case referred to medical		26. F	Place of Death	(Check only one)	1210	2 2 110		
	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3 □ DOA Other: 4 □	☐ Nursing Hon	ne 5 Nesiden	ce 6 □Other (Sp	ecify)		
uc.	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day, Ye	28b. Time of Injury	28c. Injury at Work?	2	28d. Describe how	injury occurred			
cati	2 Accident investigation		M 1 ☐ Yes						
rtifi	4 Homicide determined 28e. Place of Injury building, etc. (s	- At home, farm, stre Spe <i>cify)</i>	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or F State)	tural Route Number,		
ပ္	29a. Certifier 1 Certifying Physician: To the best of n	ay knowledge, death	popured at the time de	to and place	and due to the equ	una/a) and manner	an otatod		
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 4 Medical Examiner: On the basis of examiner and manner stated	amination and/or inv							
Me	29b. Signature and title of certifier	4 - 4	29c. License numl	ber	290	I. Date signed (Mon	th, Day, Year)		
0	Have 1 St.	10/m	2 12	0515	-8	4/13/	7009		
	30. Name and address of gerson the completed cause of death	(Item 23a) (Type, P	rint) 6/3)	5HI	90Y 5)	DER	0		
	MARNEY STEINFE	.0	5/190	1 310	E 10	1. Date signed (Mon 4 / 13 / 2 0 E / R	764		
te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature A. A.	1.41						
	APR 15 2009 Lene								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month ()U ANCUCIK NNY 2340 M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 33 East Lake Drive Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/21/1960 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗷 Hours Min. Director 577-96-9814 48 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercite must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 East Lake Drive 21403 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Smith Barney Certified Financial Planner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Francis Hancock, Jr. Patricia Ann Hare ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry L. Hancock/ Sister 15687 East Haven Court, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State Kalas Crematory 4/17/09 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Engl Mall 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 34 /Medical Due to (or as a consequence of): Examiner Wid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and burial-trai Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknow þ page 2 should Completed has certificate Be Certification: To After this

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after deatl To the Funeral Director:

Baltimore, Maryland 21215-0036

Part II. Other significant conditions c	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Deat	th (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investigand manner stated.	urred at the time, date and place, ation, in my opinion, death occur	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
29b. Signature and title of contifier	1 De A	29c. License number	29d. Date signed (Month, Day, Year)

Registrar

Medical

31. Date filed (Month, Day, Year)

Name and address of person who impleted cause of death (Item 23a) Type, Print)

W

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryl		artment of F			iene g. No. 2009	13914
			Registrar  1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physicia	an						Month April	9, 2009 Year	7:25 A ^M
	/Medio Examin		Oliver Wendel: 4a. Facility Name (If not institution,		iles	4b. City. Town, or	r Location of Death		4c. County of Death	1.23 A
	⊏xamın	ier	Southern Maryla			Clinton			Prince Ge	orge's
1,2	Funeral		•	6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		577-58-5649	1⊠M 2□F 66	Yrs.	Months Days	Hours Min.	(Month, Day, 8-31-1	942 Penr	nsylvania
	P		Usual Residence of Decedent		0 T					10.1.1.1.1.1.0.1.1.1.1.1.1.1.1.1.1.1.1.
	shov	7	10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1X\ Yes 2 \ No
	8a-f	ecto	DC		Washingt				og. Citizen of What Cou	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Experience is all the retified at once.	Funeral Director	10e. Street and Number 1854 Kalorama Re	oad NW		10f. Zip Code 20009			nited State	*
	leath	era	11. Marital Status	12. Was Decedent Ever i	in U.S. 13. \	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	can Indian,
٥	r iter		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 □Yes 2 ☑ No		_		Rican, etc.)	Black, White,	
0500-61	ral",	d by	3 Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🔀 No	Specify:		Specify: Bla	ack
ה	72 hc 'natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done	pation during most of work d)	king 1	6b. Kind of Business/In	dustry
7	ithin ne. han '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			d) -		D.C. C.	
Z	lled v Hygie ther t		17. Father's Name (First, Middle, Li	3	18	x Agent	18 Mother's Nam	e (First, Middle, M	DC Governme	ent
/land	ntal Hed of	Be	Oliver W. Holm					cite C. F		
Š	hould Id Me mark matic	오	19a. Informant's Name/Relationshi		10h Mailir	na Address (Street			City or Town, State, Zij	n Code)
<u>8</u>	d2s Ithar 17is trau		Anthony L. Holm		T	-			1s MD, 2074	·
ย์	1 an Hea tem 2		20a. Method of Disposition			sition (Name of natory or other place			20c. Location - City or To	
altimor	ages ant of it: If i		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemovai from State			:	00 0000 T	andover MD	
	artme ortan Injur		21. Signature Funeral Service	1.	Harmony N	Name and Addre			oln Funeral	Home
ă	Dep any		Auch	1) and water	34	401 Blade			twood, MD	20722
	6		23a. Part 1. Enter the disease, or o	omplications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		shock, or heart failure. List o	Sepsis						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor	nsequence of):					
	Examiner			Pneumor	nia					
-	р <u>#</u>	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a cor	nsequence of):					
	ecute ind trans	Examiner	that initiated events	с						
Š,	cate be executed ohysician and the burial-transit	ũ	resulting in death) Last	Due to (or as a con	isequence of):					
8/00,	cate be executed physician and the burial-transit	dical	`	d						
٥ ×	certifi ding se as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pro	egnancy				and Data of deli-	
Z D D	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3 [	Ectopic pregnanc Other (specify)	y		23d. Date of deliv Month	ery Day Year
j	the d	ıysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	ordeath JE					
<u>τ</u>	that ned b deta		Part II. Other significant condition	s contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
Hecords,	quires n sign ald be	d by	Coronary Arte	ry Disease				1 □ Ye	s 2 □ No 3 □ Pro	bably 4 🗓 Unknown
္ဌ	s bee	Completed	End Stage Ren	al Disease				24a. Was ar	24b. Were auto	opsy findings available
ř	The Is te ha age 2		Did beage Res	Charles to Carlo				autopsy	ned? death?	mpletion of cause of
N I I I	an; rtifica tor, p	BeC	25. Was case referred to medical			·	26. Place of Dea	1 ☐ Yes 2 th (Check only one		2 🗀 110
>	lysical lis cel direc		examiner? 1  Yes 2√√No	Hospital:	2  ER/Outpatier	nt 3 DOA Oth	or.	,	nce 6 □Other (Speci	fy)
0	ng Ph fter th neral	<u> </u>	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	28c. Injur Worl	ry at k?	28d. Describe hor	w injury occurred	
VISION	endir sath. or: At	ăți	2 Accident investiga	tion			Yes 2 □ No		<u>.</u>	
Ĕ	or Att ter de irecte n by t	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, str pecify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Run , State)	al Route Number,
ב	pital o		20 Contifier 4 1 0 and 1	Planting Table has been for						
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical		Physician: To the best of my xaminer: On the basis of examiner and manner stated.						
/	o the	Mec	29b. Signature and tile of pertiner	and mariner states.		29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
	-> F 0		* Walk!	full for		005	8218		4/15/2009	
•	1		30. Name and address of w	ho completed cause of death	(Item 23a) (Type	Print)				
	4		Dainty Jackson	. MD . 10 S	t. Patri	cks Dr. S	Suite 502	Waldori	, MD 20603	
	Sta	te	31. Date filed (Month Park 1 8 20		signature Au	w				
	Registr	ar	APR I O Zu	or there	7					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 13, 2009 6:53 A M LeRoy Hughes 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital **Clinton** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, March 7, 5. Social Security Number Months Days Hours Pennsylvania NX M 2 F 169-44-4385 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2xxNo Prince George's Clinton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8601 Adios Street 20735 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2x1XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Mental Health Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brown Walter Hughes Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara C. Hughes / Wife 8601 Adios Street Clinton, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from Stay 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 04/17/2009 Clinton, Maryland 21. Signatur Juneral Service Licenset 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiorenti Due to (or as a consequence of): 015L6 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Severt Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 □ No 24a. Was an autopsy performed? 1 X Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-clical Examinational partities at once.

Baltimore, Maryland 21215-0036

and burial-trai physician s the burial attending p cate has been signed by the page 2 should be detached certificate

Physician/Medical by Completed Be

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

the

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Division of Vital Records, P.O. Box 68760,

BI State

Registrar

23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

D0028035 9135 Pisataway Rd. #310 CLINTON, mo 20735

30. Name and address of person who completed cause of death (Item 23a) Type, Print) Basirmohmad

32. Registrar's signature

29b. Signature and title of certifie

			State of Maryland / Department State	artment of Health and M <i>rtificate of Death</i>			2 12016
	_		1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg. 2. Date of Death	No. 2009	3. Time of Death
	Physicia		Imogene Eva JACKSON			Day 2009	6:55 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
		•	Washington County Hospital	Hagerstown		Washington	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 ☒ F 7. Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co	hplace (State or Foreign untry)
	Director		214-28-2486 The residence of Decedent The residence of Decedent The residence of Decedent The residence of Decedent The residence of Decedent The residence of Decedent The residence of Decedent The residence of Decedent		Aug. 9 19	932   Mar	yland
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-fsh	ctor	Maryland Washington Hager	stown			1 □ Yes 2√∑ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	s 23a	Funeral	10808 Downsville Pike 11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Ves or No-	USA 14. Race - Ame	rican Indian.
_	ter de	Fun	1 Never Married 2 Married 1 TYes 2 N No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
20	urs af	þ	If Yes, Give 3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐Yes 2X No Specify:		Specify: Whi	te
ה ה	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/	Industry
7	/ithin	mp	Elementary/Secondary (0-12) College (1-4or 5+)			School	,
Z	filed v Hygie Ither I		12 0 Nurs	ing Assistant  18. Mother's Name	e (First, Middle, Maid		L
<u>a</u>	ld be lental ked o ic eve	To Be	Keller Adam Burns	Nellie	Lewis		
ary	shou and N s mar			ng Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, 2	Zip Code)
, E	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The stand and Mental Hygiene.  The marked other than "natural", or Items 23a or 28a-f show other traumatic event, Item Myddonl Even, inc. is ust be realthed at		-7	Rock Willow Avenue			
20	ges 1 If of H or oth		20a. Method of Disposition 20b. Place of Disposition 1 △ Burial 2 □ Cremation 3 □ Removal from State	matory or other place)		. Location - City or	
aiiimor	it. Par intmen intant: njury			1 Cemetery 4/21, 2. Name and Address of Facility Min			, Maryland
מ	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.			15 E. Wilson Blvd			land 21740
ľ			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
٠.	Physician			nichive fulmo	nam Di	Sease	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			
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	uted t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause indeed) lest				
,	exectian and rial-tra	Еха	resulting in death) Last  C.  Due to (or as a consequence of):			-	
8/00,	icate be executed physician and the burial-transit	dical	d				
	ertifica ling pl		IF FEMALE:	-			
X Q	attend for us	ian/	In the past 12 floridisa	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
j	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	1 Yes 2 12 No 9 Unknown				
7.	s that ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ecords,	equire; en sig ould bi				1/1Xes	2 No 3 P	robably 4 🗌 Unknown
သူ	law re las be	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	: The cate h	Con			performed	d? death? 1 ☐ Yes	2 □No
VII	sician certifi rector	Be	25. Was case referred to medical examiner?	Other:	th (Check only one)	A [[0]]	
Ö	Physer this eral di	<u>1:</u>	1	ent 3 DOA 4 Nursing H	ome 5 ☐ Residence 28d. Describe how		ecity)
0	nding ath. r: Afte e fune	atio	1 ☐ Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
UNISION	r Atte er dez recto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
5	intal or lars aft					(-)	
	To the Hospital or Attending Physician: The law requires that the death certific Within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	e and place, and du	e to the cause(s)
	To the within To the Compl	Me	29b. Signature and fifte of certifier	29c. License number	29d	. Date signed (Mon	th, Day, Year)
	62		saoua, as	D62588	A	pril 19th	, 2009
•	-3		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1 mg - 2 mg	MA	
			JUDITH MRAOUA W 2SI t. An  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	inetom St. Hag	03100	1,14	
	Sta Registr		APR 2 0 2009	and I			

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

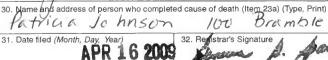
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 APr. Day **Physician** 7:00 PM JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner he sapeake Woods Nursing Center Dorchester ambridge 8. Date of Birth (Month, Day, Year) 7 0 14 26, 1927 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yre. last birthday) Birthplace (State or Foreign Country) 1 M 2 M F **Funeral** Days 218-20-861 8 Months Hours Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director Dorches ter 10e. Street and Number 10f. Zin Colle 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 72 hours after 1 Yes 2 Polices: 1 Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 WNo Specify 2 Black 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSP; Dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) uth and Mental h Be 010 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traur 43 o Lecompte ambridge, MD, 2161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge, Bethel Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HENRY FUNERAL HOME, P. A. 510 Washington St. Can MD. 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Cancer a months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it among the first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOO 59973

State Registrar

31. Date filed (Month, Day, Year)

Jo hnson



Cambrid & MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 13 1:14 AM Crescelius JOHNSON -2009 Vivian 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Coastal Hospice at the If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🗗 F Months Days Hours 220-28-2439 Aug. 8, 1932 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or items 23a or 28a-f show Injury or other traumatic event, the Middell Examiner aust be notified at 1 Tryes 2 □ No MD **Funeral Director** Dorchester ambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1606 axMore 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: ģ Specify: Black Pages 1 and 2 should be filed within 72 hours 3 ☐ Widowed 4 ☑ Divorced than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Health Department of Health and Mental Hygie important; If item 27 is marked other in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Josephine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O.BOX 531-1606 Paxmore Ln Cambridge, MD. 21613 Joan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/09 Mt. Pleasant Cemetery. Salem, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility HENRY FUNERAL HOME, P. A. 510 Washington St. Cambridge 21. Signature of Funeral Service Licensee MD. 2/6/3 23a. Part - Enter the disease, or complications that caused the dead. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -nterocorcu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an has autopsy certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10501 ( 200 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death Pruneral Director:

Maryland 21215-0036

Baltimore,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of contine

To the I

State Registrar

Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Rox 68760 Division of Vital Becords

		For State	State of Mar		Depa		lealth and I				
Physicia /Medic		Registrar  1. Decedent's Name (First, Middle, L.	est) ETER		Cei	tificate of	Death	2. Date of De Month APRIL	Day	2005	3. Time of Death 5: 25 A M
Examin Funeral Director	er	251-50-7609	D HOSPITAL	iln yrs. last b	<i>irthday)</i> Yrs.	4b. City, Town, or CLINTC  If Under 1 Year  Months Days	N If Under 24 Hrs. Hours Min.		th ay, Year)	Cou	
e Maryland 3a-f show tiffed at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD PRINCE GEORGE'S SUITLAND									10d. Inside City Limits 1 ∰Yes 2 □ No
S should be mean writh 7.2 hours after death with free maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it is Medical Examiliar must be notified at	Funeral Dire	10e. Street and Number 3226 SWANN ROAD 11. Marital Status	#102  12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	10f. Zip Code  20746  Was Decedent of He f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	USA	zen of What Cou	ican Indian,
natural", or it	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	168	a. Deced	l □Yes 2ሺ No dent's Usual Occup	Specify:			Specify: BI	ACK
Hygiene.  Other than "rent, In Mod	e Completed	(Specify only highest given the secondary (0-12) STH  17. Father's Name (First, Middle, Las	College (1-4or 5+)	R	life. L	kind of work done of NOT use retired	1)			ERAL MOT	CORS
and Mental Is marked of raumatic ever	To Be	RUSSELL JETER  19a. Informant's Name/Relationship	(Type. Print)	1		g Address (Street	CATHLE and Number or Ru	EN RAY			ip Code)
perfiller rages i allo 2 should Department of Health and Mer Important: If Item 27 is marke any Injury or other traumatic once.		ALLEN W. JETER /  20a. Method of Disposition  1 \( \mathbb{M}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( (4 \) Donation 5 \( \mathbb{O}\) Other (Spec	Removal from State	20b. Place o	of Dispos ery, crem	64TH STRE sition (Name of natory or other place N NATIONA	e)	Date	20c. Lo	cation - City or T	own, State
Department of himportant: If ite any injury or ot once.		21. Signature of Guneral Service Lice 23a. Part 1 Enter the disease, or cor shock, or heart failure. List only	nee		22	Name and Address	ss of Facility MA ITLAND R	OAD SI	S FUN	CLAND, M NERAL HO AND, MD	ME OF MD 20746
E igi	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c  Due to (or as a c  Due to (or as a c  d.	onsequence onsequence	of):	enhe (	20000	anun	nds	sen.	Onset and Death
ned by the attending physic detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown							23d. Date of delivery Month Day Year		
s been signed b should be deta	Ď	Dicheren Meldichen							d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably Unknown		
uis certificate has director, page 2 s	Be Completed	24a. Was an autopsy findings availal prior to completion of cause of death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)								ompletion of cause of	
fter this	Certification: To	1   Yes   2   No									
in 24 hou he Funer pletely fill	edical	one) 2_\medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	amination a	e, death	estigation, in my o	pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)
Mil Pino	2	29b. Signature and title of certifier  Authorized by Authorized Signature and address of person who	completed cause of deat	) h (Item 23a)	(Type, F	29c. License D 5 0 Print) AN L	GEG	A Zaw	04 MD	e signed (Month)	009
Stat Registra	e	31. Drafiled (Month, Day, Year)	32. Registrar's	Signature	110	750	3 54~	CHIR	0 R-01	Chan	n mb 207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 PER FH G892 6/02/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 18 0941 Virginia Eleanor Kincaid 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3143640 NICOMICO PLNINSHM centu If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
Ohio 8. Date of Birth (Month, Day, Jan. 17 282 =30 V 663 6 Sex 7. Age (In yrs. last birthday) Year) 1934 **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Jan. 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Examinator mast be retified an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 1 ☐ Yes 2 X No Directo Greenwood Sussex Delaware 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19950 USA 10206 Fawn Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Schaudi Milton C. Burchnell P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10708 Fawn Road, Greenwood, Delaware 19950 Linda Kitchen/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4/24/2009 Clifton, Ohio Clifton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 110 Main Street, East New Market, MD 21631 21. Signature / Funeral Service License Approximate Interval Between Onset and Death 5 days Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Immediate Cause (Final Comelications **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner anoxic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed Status and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No ed by the 9 Unknown signed by the detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After Injury 5 Pending investigation 1 Natural 8 tall from step) 1 ☐ Yes 2 XNo 4/13/09 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 10206 Favon Rd. Greenwood Del home To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number nd title of de 29b. Signature ar 450497 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salis bury MA 2180 SNYcles Carroll 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 21 2009 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 April 18, 5:20 P M Howard Kenneth Kern 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, Hours Months Davs Pennsylvania 176-32-1941 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes 2 ☑ No Great Mills Maryland St. Mary's 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20634 USA 21611 Chancellors Run Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Sheriffs Department Correctional Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Miller Earl Kern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23395 Maypole Road, Leonardtown, MD 20650 Nancy Lawrence/Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4/28/2009 Cheltenham, Maryland Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC ADENOCARCINOMA Due to (or es a consequence of):

29d. Date signed (Month, Day, Year)

4:20:2009

**Physician** /Medical **Examiner** 

Examiner

**Physician** 

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examination once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

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Completed

Be

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Physician/Medical filled in by the 24 hours a

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Completed

Be

Certification: To

Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LEENA

RAO

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Lue to (or as a consequence of):  C.  Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of de Month	elivery Day Year		
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	/		
CHRONIC KI	DNEY DISEASE	autopsy prior to performed? death?	utopsy findings available completion of cause of s 2 \Boxed No		
25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)			
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing He	ome 5 ☐ Residence 6 ☐ Other (Spe	ecify)		
27. Manner of Death  ↑ Natural 5 Pending 2 Accident investigati		28d. Describe how injury occurred			
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	'hysician: To the best of my knowledge, death occurred at the time, date and place iminer: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.				

, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI

DHMH 17 Rev 1/2001

To the within 2

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**ORIGINAL** 

29c. License number D67788

Charlotte Hall, MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar	yland / Depa		of He	alth an	nd Mental		e 2 n n	9	13922
	Physici	an	Decedent's Name (First, Middle, Last	)						of Death	Day Ye		3. Time of Death
	/Medi		Bernice C. Knott						APR	IL 1	0 20	19	11-25A M
A	Examir	er	4a. Facility Name (If not institution, give					ocation of [	Death		4c. County of E	eath	
			Sanctuary at Holy ( 5. Social Security Number   6. Se		nsville In yrs. last birthday)	Burt If Under 1		ille If Under 24	Hre a Day		Montgom		
	Funeral Director			M 2 K	91 Yrs.	Months	Days		Min. (Mont	of Birth h, Day, Yes 9/191		Country ebra	se (State or Foreign ') ska
	iand iand		10a. State 10b. County	1	Oc. City, Town or Lo	cation						10d	. Inside City Limits
	death with the Maryland ms 23s or 28s-f ehow rmst be notified at	ğ	Maryland   Prince Go	eorge's	Hyattsvil	lle							1 🛣 Yes 2 🗌 No
	1 the	Funeral Director	10e. Street and Number			10f. Zip 0	ode			10g.	Citizen of Wha	Country	?
	3a o	0	6834 Standish Driv	7e		2	0784				JSA	,	
	deati	ner	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decede	nt of Hisp	anic Origin	? (Specify Yes Puerto Rican, etc		14. Race - /		
9	after or Ite		1 Never Married 2 Married	Armed Forces?  1  Yes 2  No If Yes, Give	1	rres, speci 1 ∐ Yes 21			uerto Hican, et	:.)		Vhite, etc	
21215-0036	rel',	d by	3   Widowed 4   Divorced	Year or Dates:		10195 2	AJ NO	Specify:			Specify:	Wn	ite
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12	hen hen	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	2.5	DO NOT use	retired)						
2	should be filed within and Mental Hygiene. • marked other then " umatic event, the Mer	ပိ	17. Father's Name (First, Middle, Last)		Mana	iger		0 14-45-4-	Name (First, M			Chi	na Shop
au	od of o	To Be	Louis Binder				"						
Ž	hould d Me mark matic	F		ena Printl	10h 14-iii-		C11		ia A. Pr				
Maryland	d 2 sign and 7 ier		19a. Informant's Name/Relationship (Ty						or Rural Route N			ө, <i>Zip Сс</i>	ode)
e,	Healt Healt Healt ther	- 1	Sheila Paterno - I		14106 20b. Place of Dispo	Yard	Arm	Way,	#1011	Laure	1 MD Location - City	2070	
Baltimore,	ages or o		1 Burial 2 Cremation 3 ☐F		cemetery, crer	natory or oth	er place)	/-					
量	rtmer rtent njury		4 Donation 5 Other (Specify)		Fort Line			- 1				-	
Ba	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Innortent: If item 27 ie marked other then "nature!; or Items 23a or 28a-f show eny injury or other traumatic event, Ins Medical Experimentment be notified at ORGs.		21. Signature of Funery Serve Licens	Will					Fort Li Rd., B				ome 1722
	eath certificate be executed attending physicien and for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to minimal acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	or sequence of):	, (	AN	CET					nset and Death
	rtifica ng ph as th	Med	IE EEMALE.										
P.O. Box	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic preg Other (spec				_	23d. Date of Month	delivery Da	y Year
Records, F	quires the n signed uld be det	P	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the ur	nderlying cau	se given	in Part I.		Did tobacco		e to the d	eause of death?
ပ္ပ	sw requir s been si should I	Completed							24a.	Was an	24b. Were	autopsv	findings available
<b>E</b>	The law cete has page 2.	E								autopsy performed?	prior	to compl 1?	etion of cause of
		0	25. Was case referred to medical				2	6 Place of	Death Check of	STATE OF	No 1 1 1	es 2	☑ No
<b>&gt;</b>	Physician: this certific ral director,	To B	examiner?	lospital:	2 ER/Outpatien	t 3 DOA	Other:		ng Home 5	100	6 MOther /6	`=====	
10	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at Work?	-			lury occurred	респу	
<u>.</u>	ath. r: After e funer	ate	2 ☐ Accident 5 ☐ Pending investigation	(Month, Day Ye	ea <i>r)</i> Injury	М		s 2 No					
Division	after des Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, o	office		28f. Locat City o	on (Street r Town, Sta	and Number of	Rural R	oute Number,
:	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	occurred at restigation, in	the time, my opini	date and p	lace, and due to	the cause	(s) and manner nd place, and	as state	d. e cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	,		29c. l	icense n	umber		29d. D	ate signed (M	onth, Dav	v. Year)
	- > - 0		Manuary 1	1000000	0		N	2800	ac-			M3	
	17	-	30. Name and address of person who co	moleted cause of death	(Item 23a) /Type	Print)	1)	V 07	- ( )	-	7/10/	01	
	10		TASNEEM LA	KHANI,	2 8 35°	Sm1	T74 .	AYE	as ⁻ 1 Suitt	2/3	BA	ero	MDálza
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 6 200	9 37. Registrar's	Signature As &	Mind							

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^D4^y / O^{Month} (J.B. 1029 am Ali Khan Α. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Cheverly Prince Georges Hospital Cntr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Days Months 65 578-56-4288 08/01/1943 Wash. DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Mitchellville Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1408 Brady Ct. 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lottie Mary James James Aaron Richmond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ophelia Khan / Wife 1408 Brady Ct. Mitchellville, MD 20721 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Ceme. 04/17/09 Brentwood, MD 21. Signatura | Funeral Service 🚧 22. Name and Address of Facility Universal Mortuary Inc. 411 Kennedy St NW, Washington, DC 20011 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final CARDIAC ARRHYTHMIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and locality cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗷 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, this After 1 death. within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar roust by notified at

ulth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me

Department of Health ar Important: If Item 27 is any Injury or other trau once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 X No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)

MD 3001 DAVIS

CHEVERLY, MD

State Registrar 31 Date filed (Month, Day, Year) APR 1 6 2009 32. Registrar's Signature 1. pare

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Ammend #23a, b, St. Mary's, DLB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mary Cecelia Long Year 9;46 am 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death No harle If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days 215-30-0043 Hours Min 85 Yrs August 6, Director 1923 Usual Residence of Decedent 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I'm Mudical Evanting must be nothing a Director Maryland St. Mary's Mechanicsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 USA 39251 Danielle Way Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify 3⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: if item 27 is marked other tha any injury or other traumatic event, Ital 200ce. Waitress Restaurant 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Burch Betty Knott ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39251 Danielle Way Mechanicsville, MD 20659 Linda Quade / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State April 20 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland Trinity Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2009 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. nchael P.O. Box 270 Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Aspiration Pnuemonal /Medical Due to (or as a consequence of) Examiner Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due lo (or as a consequence o Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy Division of Vital 1 □ Yes 2X No : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 24 hours after death. investigation 1 □ Yes 2 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only onel within 2 the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 2000 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

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State Registrar

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mary				Mental Hy	giene			
			State Registrar		C	ertificate of	Death		Reg. No. 2	9 13925		
	Physicia	n	Decedent's Name (First, Middle, Last	2. Date of Dea Month	Day Yea							
-	/Medic			Bertha Leon	1	AL O'R. Town	April	11 200 4c. County of De	9 9:11a			
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,	П					
			Northampton Manor  5. Social Security Number 6. S		ne yrs. last birthd	17.1	rederick	8. Date of Birt	h Fred	erick irthplace (State or Foreign Country)		
H	Funeral Director			□M 2MF	6 Yrs	Months Days	Hours Min.	June 2		ew York		
	ъ		Usual Residence of Decedent					TO GITO I	.,			
	how	_ [	10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Limits		
	a-f s	양	Maryland Frede	rick	Walker					1 ☐ Yes 2 😿 No		
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?		
	23a		223 Diamond Drive				1793		United S			
	tems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show art, the Modical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give Year or Dates:		1 □Yes 21☑No	Specify:		Specify:	hite		
21215-0036	stura	ed	15. Decedent's Ed	lucation	16a. De	ecedent's Usual Occ	upation		16b. Kind of Busines			
7.2	in "in Media	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	- (G	ive kind of work don e. DO NOT use retir	e during most of wo. ed)	rking				
5	d with giene er tha	ĕ	12	College (1 401 01)		Homemake	er		Own Hom	e		
g	al Hy al Hy l oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)			
Val	Ment Ment arkec artic e	2	Unknown				Ida Ros	eman				
a	2 sho		19a. Informant's Name/Relationship (	Type. Print)	19b. M	ailing Address (Stree	et and Number or R	ural Route Numbe	er, City or Town, State	e, Zip Code)		
≥,	and fealth m 27 her tr		Anna Notafranceso	/ Daughter	223	Diamond I	Drive, Wa	lkersvil	le, Maryla			
00	ges 1 If of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		sposition (Name of crematory or other pi	i		20c. Location - City	or rown, State		
ᆵ	t. Par tmen tant: ijury		4 ☐ Donation 5 ☐ Other (Specify		tayffer	Cremator		4/2009	Frederick	, Maryland		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ite Modical Examiner must be notified at ance.		21. Signature of uneral Service Licer	le Could		22. Name and Add Stauffer	ress of Facility Funeral H	omes P.	A	ryland 21702		
			23a. Part 1. Enter the disease, or com	plication that caused the						ryland 21/02   Approximate		
b			shock, or heart failure. List only	one cause on each line.	1 .	,				Interval Between Onset and Death		
W.	Physician // // // // // // // // // // // // //		disease or condition resulting in death)		heim.	055 /4	ireare	_				
1	Examiner		Due to (or as a consequence of):									
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	nsequence of):							
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0								
oʻ	exection and and rial-tr	Еха	resulting in death) Last	Due to (or as a co	nsequence of):							
68760,	icate be executed physician and s the burial-transit	edical		d								
			IF FEMALE:									
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as it.	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		3 ☐ Ectopic pregna	ncy		23d. Date of Month	delivery Day Year		
0	e deg	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e of death	5 ☐ Other (specify)				July 10th		
<u>o.</u>	w requires that the dispersion is been signed by the should be detached		Part II. Other significant conditions of	contributing to death but no	ot resulting in th	ne underlying cause o	niven in Part I.	23e. Did t	obacco use contribute	e to the cause of death?		
g,	ires t signe d be c	by	Tarrii. Othor organizations	on locality to death but he	or reconning in a	io andonying sauce s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 🗆 '	Yes 25√10 3□	Probably 4 Unknown		
Ö	requ	Completed										
æ	has has	mpl						24a. Was autop perfo	osy prior death	autopsy findings available to completion of cause of ?		
<u>a</u>	n: Th ficate r, pag		OF Man and a madical					1 □ Yes	No 1□Y			
Division of Vital Records,	sicia certi recto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2. No	Hospital:	2 C EB/Outs	2 DOA C	thor: 1	ath (Check only o				
o	Phy arthis arald	Ξ̈́	27, Manner of Death	28a. Date of Injury	28b. Tin			1	dence 6 ☐ Other (S how injury occurred	респу)		
o	nding tth. : Afte	i	Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	e <i>ar)</i> Inju		ork? □Yes 2□No					
Vis.	Atter	ifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, farm	, street, factory, offic	е	28f. Location (. City or To	Street and Number or	Rural Route Number,		
Ö	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page.	Certification: To	4Hornicide	building, etc. (c	эреспу)			Oily of 10	wii, Olalej			
	ospital hours uneral			hysician: To the best of m								
	To the Ho within 24 To the Fu completel	Medical	one)	and manner stated								
_	To the within To the comple	2	29b. Signature and title of certifier	11.			nse number		29d. Date signed (Mo			
			1 / Jenel	M us			03/058		4-1.	3-09		
	2		30. Name and address of person who					1 10:	700			
	- 01-		Gene F. Ashe MD 1 31. Date filed (Month, Day, Year)	U2UU Coppern	nine Ro	ad, Woods	ooro, Mar	yiand 21	798			
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DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 April 14, 9:20 PM Robert Boyd Ladd 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Wilson Health Center Gaithersburg 8. Date of Birth (Month, Day, Mar 16, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year)} 1915 Months Days Hours Texas 1 X M 2 □ F 450-20-3996 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20877 USA #313 333 Russell Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Statistician Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Schostag Arlington Ringold Ladd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 N. 3rd Street Mebane, NC 27302 Robert J. Ladd/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 04/16/09 Odenton, MD W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Montes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death weeks Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 T Unknown 23e. Did tobacco use contribute to the cause of death? 2 🗖 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe chronica 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner or Attending Physiclan; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician ed by the a this funeral ( After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Inc. Inc.

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**Physician** 

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Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Yes 2 No 27. Mann of Death 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

8 EG.

29b. Signature and title of certifier

29c. License number 04115

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a (Type, Print) H. ROBERT SIRSCHBACH MA 31. Date filed (Month, Pay

201 RUSSELL AVER CAITHERSBURG, MIS

State Registrar

Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02680 State of Maryland / Department of Health and Mental Hygiene Roche Laughlin 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 5, 2009 **Medical Examiner** Roche Quintell Laughlin 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Park Baltimore Avenue at Sheridan Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 1 X M 2 22 1980 578-04-1931 28 Yrs Auq Usual Residence of Decedent 10c. City, Town or Location 10a, State 23a or 28a-f show notified at once. DC DC Washington Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 5218 Fitch St., 20019 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes Yes 2 X No specify: If Yes. Give Year Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12th Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria Jean Peoples Be Unknown 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 item 27 is 3025 Oaklawn Ave, Largo, Antonio R Peoples -Brother FL20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, 009 crematory or other place)
Riverdale Park Cre Burial 2 X Cremation 3 20 Riverdale, MD Department mportant Donation 5 Other Specify: 22. Name and Address of Facility DL McLaughlin Funeral 2019 MLK Jr Ave, SE, Washington DC 21. Signature of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease. **Physician** failure. List only one cause on each line. /Medical Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical physician a the burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ Completed Records, 24a. Was an this certificate has been autopsy Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician; 25. Was case referred to medical Division of Vital Be Other-Hospital: DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Apr 5, 2009 After t 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification; 0146 hrs Natural Yes 2 V No Pending after death. the Director:

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 1 Residence 6 V Other: Scene 28d. Describe how injury occurred Driver auto fixed object collision 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Baltimore Avenue at Sheridan Street, University Park, M determined (Specify) Local Street Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) Signature and title of certifier 29c. License number April 5, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner gistrar's Signatur 32 31. Date filed (Mont State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

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10d. Inside City Limits

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Death

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14. Race - American Indian, Black,

Prince George's

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Private

Specify: Black

Amend #5, perFH g893_7/2/09_TT
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7	Funeral Director		5. Social Security Number 239-64-3464	6. Sex	M 2□F	7. Age (In yrs. 69		ff Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of 8 (Month, 3/8/4	Birth Day, Year O	)		olace (State otry) :h Car	
ore, Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Exp. direct must be multified at 90se.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. Coun  MD  Princ  10e. Street and Number  1624 Drexe1  11. Marital Status  1 Never Married 2 Marital Status  15. Deceding only high  Elementary/Secondary (0-12  12  17. Father's Name (First, Middle David King Lil  19a. Informant's Name/Relation  Sarah Jackson  20a. 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Division	or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:	1 Naturaf 5 Peni 2 Accident inver 3 Suicide 6 Coul	stigation	(Mont	h, Day Year) of fniury - At h	Injury	М	Worl	⟨? Yes 2 □I	No	28f. Location	(Street a	nd Numbe		al Route Nur	nber,
٥	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		4 Homicide dete	ying Phys	sician: To the	best of my kno	owledge, deat	h occurred	at the tin	ne, date an	d place, a	and due to th	own, Stai	s) and man	iner as s	stated.	
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	10		30. Name and address of person	on who co	mpleted caus	e of death (Iter	m 23a) (Type,	Print)					1				
	10		Dr. Brent		5530 V	liscons	in Ave	. Che	vу С	hase,	Mar	yland	2081	5			
100	Sta Registr		31. Date filed (Month, Day, Yea	2009	Senes	egistrar's Sign	ature	4									
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>009</u> **Physician** 9:45 P Ngan Suong Thi Mai April 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14028 Rockingham Road Germantown Montgomery 8. Date of Birth (Month, Day, Year) 01/20/1958 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. Yrs Director 51 Vietnam 215-41-8496 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 14028 Rockingham Road 20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō If Yes, Give Year or Dates: 1 Yes 2 XNo Specify. ğ Specify: Asian 3 ☐ Widowed 4 🔀 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 12 Manicurist Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Nhung Thi Pham ၉ Ly Viet Mai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14028 Rockingham Road Germantown, MD. 20874 Philip Kmiec (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aprilie 17 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia <u>Metropolitan Crematory</u> 21. Signature of Funeral Service Licenser 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 Years disease or condition resulting in death) Colon Cancer, Metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy performed? 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatyre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D038262 April 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd. #340 Rockville, MD. Anurita Mendhiratta M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State arted Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 6:00 $\mathbf{P}$ M 2009 CHARLOTTE CONNER BAUSERMAN MCDONALD APRIL 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT LONDONDERRY ASSISTED LIVING EASTON 8. Date of Birth (Month, Day, Year) JANUARY 5, 1925 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours Months Days Yrs MARYLAND 84 Director 578-20-9607 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov ms 23a or 28a-f shov 1 XYes 2 □ No Director EASTON **MARYLAND** TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 700 PORT STREET # 107 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 □Yes 2 No Exa 2 Specify: WHITE 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **FEDERAL** Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 27 is marked o traumatic eve MALPH BAUSERMAN GRACE CONNER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 PEBBLE BEACH DRIVE, LEAGUE CITY, TX 77573 HOWARD OSTMANN/SON item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) ST JAMES CHURCH CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any Injury or once. = ১ APRIL 18, 4 ☐ Donation 5 ☐ Other (Specify) 2009 STAR TANNERY, VIRGINIA 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final **Physician** ORONALY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð HYPERTENSION cate has been signated bade 2 should b 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed HYPERLICIDEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □No 1 ☐ Yes 2 □No 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 2 **N**0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury death. i 24 hours after death. e Funeral Director: △ letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the I within 2, To the F

State Registrar

npletely

Medical

29a. Certifier

29b. Signatu

(Check only one)

Year

2009

16

DHMH 17 Rev 1/2001

s of person who completed cause of death (Item 23a) (Type, Print)

Mn

. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 37064

Sallit Dr Storensulle

29d, Date signed (Month, Day, Year)

21666

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Mar	yland / D	epartme	nt of Heal	th and M	ental Hy	giene	10001
			1 - State Registrar			Certifica	te of Dea	ath		Reg. No.CUUY	13931
	Physicia	an	1. Decedent's Name (First, Middle,	•	McDonou	ah			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Geraldine  4a. Facility Name (If not institution,		MCDOHOU		Town, or Locat	tion of Death	April .	20, 2009 4c, County of Dea	_ 7:35 p ^M
	Examin	er	37534 Harrow H	,							
ı	Funeral			6. Sex 7. Age (	(In yrs. last birti	Months	echanics erlYear IfUr Days Hou		8. Date of Birt (Month, Da	h 9. Bir	Mary s thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	1 □ M 2 X X F	85	rs.			Jan. 28	, 1924 Per	nnsylvania
	/land		10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	e Mar	ctor	Maryland St.	Mary's	Me	chanics	ville				1 □ Yes 2√1 No
	vith th	Director	10e. Street and Number			10f. Z	p Code			10g. Citizen of What Co	ountry?
	eath v	Funeral	37534 Harrow H	111s Court 12, Was Decedent Eve	er in U.S.	13. Was Dece	2065		cify Yes or No	USA	erican Indian
9	after d or iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ed 1 ∐Yes 2 🛣 No			edent of Hispanie ecify Cuban, Me		Rican, etc.)		
21215-0036	ural", c	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes		ecify:		Specify:	White
-5	n 72 h "natu	Completed	15. Decedent' (Specify only highes	t grade completed)		Decedent's Us (Give kind of w life. DO NOT I	ual Occupation ork done during : ise retired)	most of workir	ng	16b. Kind of Business	/Industry
212	d withigiene.	omi	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema				Own Hon	ne
D	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, L							Maiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exemple and I've notified at once.	၀	Jerimiah P.	McDonough				athryn	М.	Doyle	T 0 1)
<u>8</u>	d 2 st Ith an 27 Is r r traur		19a. Informant's Name/Relationsh Michaela Tanner		17	•				er, City or Town, State, . anicsville,	
ē,	s 1 ar of Hea ltem 3		20a. Method of Disposition			Disposition (Na , crematory or			ate	20c. Location - City or	
<u> </u>	Page nent c ant: If ury or		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ry Ceme		04/27	7/2009	Pittsburgh	ı, PA
Baltimore,	ermit. epartr nporta ny inj		21. Signature of Funeral Service L	1		22. Name a	nd Address of F	acility	uneral	Home, P.A.	
_	<u> </u>		Kyle Simons M								1. MD 20622
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	inly one cause on each line.	ie death. Don	ot enter the mo	de of dying, suc	m as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence o	f):					
	Examiner		Sequentially list conditions	b. =	,						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe Universe Consequence of injury								
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80	ertifica ing ph e as th		IF FEMALE:	1							
ô	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐ Ectopic 5 ☐ Other (s				23d. Date of de Month	livery Day Year
j	the de	ysic	1 □ Yes 2 No 9 □ Unknown	9 Unknown	me or deam	5 □ Other (s	респу)				
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ecords,	require een si oould b								1 500	fes 2□No 3□P	robably 4 ☐ Unknown
မှ	e law has b	Completed							24a. Was		utopsy findings available completion of cause of
Ta Ta	in: Th ificate or, pag	e Co	25. Was case referred to medical					DI	1 □ Yes	2 No 1 ☐ Yes	s 2 □No
<u> </u>	ysicia is cert directo	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 🗆 ER/Out	patient 3 🗆 D	Other		(Check only o	<i>ne)</i> dence 6 □Other (Spe	ecify)
n or	ng Ph fter th meral	Di:T	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury	28b. T		28c. Injury at Work?			now injury occurred	
<u> </u>	tend! leath. tor: A the fu	cati	2 Accident investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation inves	ation		М	1 ☐ Yes				
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	ospita hours uneral	O	29a, Certifier 1 Certifying	g Physician: To the best of examiner: On the basis of e	my knowledge	death occurre	d at the time, da	ate and place,	and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	one)	and manner state			c. License numl			29d. Date signed (Moni	
	<b>7</b> . № <b>6</b> . 0		29b. Signature and title of certifier	nn)	)	25		575 575		29d. Date signed (Mont	
	bon			who completed cause of dea	th (Item 23a) (	Type, Print)					
	-10		Jephifer S		Signature		Leonardt	own, M	aryland	1 20650	
	Sta Registra		31. Date filed (Month, Day, Year)	33. Registrar's	s Signature	bares					
			APR 23-2	103	1						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year JANET ROSE MARTIN 11, 2009 9:10 A M April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Min. 201-18-5585 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7037 Blue Mountain Road 21788 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Shipping Clerk Moore's Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Haugh, Sr. Annie Gift 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy J. Kennedy / Granddaughter 22 Mantle Court, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 4/15/09 Frederick, Maryland 4☐Donation 5 ☐Other (Specify) 21. Signal of Funeral Service 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, shock, or heart failure. or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ATHENO Scienosi disease or condition resulting in death) GRENARY ANTERY Due to (or as a consequence of) Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 26. Place of Death (Check only one Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, Physician/Medical signed by the a P.O. Division of Vital Records, \$ After this certificate has been s funeral director, page 2 should Completed Be Hospital or Attending

in 24 hours after death.
The Funeral Director: Af within 2

Certification: To Medical

**Physician** 

Examiner

**Funeral** 

**Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evancian must be notified as

Department of Important: If any Injury or once.

**Physician** 

/Medical

Examiner

altimore, Maryland 21215-0036

/Medical

Direct

Funeral

à

Completed

Be

25.	Was case examiner?	referred to medical
	1 ☐ Yes	
27.	Manner of	Denth

29a. Certifier

(Check only one

5 Pending investigation

1 Natural 2 Accident 3 ☐ Suicide 6 Could not be determined 4 Homicide

29b. Signature and title of certifier

Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D00 4795

HOUSE- AUF TREDERICK

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

8/11 >1BTE A KAZHI MM TOIL 31. Date filed (Month, Day, Year)

APR 15 2009

32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g891 5-1-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Don Ε. Moore Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Hospice Harwood 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F 81 Ohio Director 276-24-8787 May 28, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ral", or items 23a or 28a-f shov 1 ☐ Yes 2 TNo Director MD Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12218 Westview Drive 20772 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 X Married If Yes, Give Year or Dates 1945-46 1 ☐ Yes 2 XNo þ Specify. Specify: White 3 Widowed 4 Divorced "natural", Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, I'm Middell once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Human Resources Federal Government 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Don E. Moore Sr. Sara Webb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary H. Moore/Spouse 12218 Westview Drive Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licer 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one uons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** oon Lan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or Lijury that initiated events Due to (or as a consequence of): Physician/Medical Examiner burial-transi resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy 1 ☐ Yes 2 **[2**KN]0 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) \( \text{Specify} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1. 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. within 24 hours a

To the Funeral C

completely filled To the Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, Year) APR 15

29b. Signature and title of certifier

30. Name and address of pers

32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

Registrar

29d. Date signed (Month, Day, Year)

Annapoli Mis alto

Bestque Rd Sufe 300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 04 Day **Physician** 0530A M 2009 Johnson Diane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HIOSMIO 34/1364/4 TENINSULD REGIONAL IDIPAL CENTA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ F Months Hours 60 217-52-2417 January 29, 1949 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at 1 ☐ Yes 2 X No Eden Director Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21822 5092 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mano If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status be filed within 72 hours after 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private family Home Domestic 12 th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eldridge Whittington Johnson C. trances 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. Morris 509 Sailfish Drive, Eden Rochelle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20/09 Upper Fairmount med Centennial Chuzancemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anthony E. Ward Funeval Home 21. Signature of Funeral Service Licensee Author E. Ward 30639 Princess Anne, md, 21853 23a. Part 1. Enter the obease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MITHEMOSCIENTIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2 EINo spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 6 24 hours a To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar DHMH 17 Rev 1/2001

IB

MD

OPA 32. Registrar's Signature CARROLL ST. SAlisbury Mid. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 6:06 A M 2009 Ronald McKinley Lee Norris, Sr. 8 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) r 16,1945 Maryland 1 X M 2 □ F Months Days Hours Min. 63 December <u> 217-42-9652</u> Usual Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 1233 Salem Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Lorraine McClay Claude McKinley Norris, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa L. Evans - Daughter 1233 Salem Avenue Hagerstown, Maryland 21740 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Smithsburg Crematory April 21,2009 4 Donatie 5 Other (Specify Smithsburg, Maryland 21. Sign ture of uner Osborne Arthrefally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DUSLASA CHYON: C disease or condition resulting in death) Due to (or as a consequence of) COVONANY Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐No g Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital:

Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi P.O. Box 68760, Physician/Medical signed by the a d be detached for of Vital Records, Completed by s peen s To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s Be Certification: To Division

**Physician** 

Examiner

/Medical

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Medical Expriner mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 300c.

death with the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

13H-2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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29d. Date signed (Month, Day, Year)

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

ARID

31. Date filed (Month, Day, Year) APR 21 2003 32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Theodore R. Nash 2009 /Medical 0218 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country) Prince 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Hours Months Days Min. 1 X M 2 □ F 88 Director 1,1920 255-64-0853 June GA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Desical Experience and the controlled at Director 1 XYes 2 □ No MD PG Capitol Heights 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with 1212 Chapel Oaks Drive 20743 Funeral <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ∐Yes 2 **X**No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Black Specify. ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 6 <u>Maintenance</u> Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Willie B. Bensen Nash ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1212 Chapel Oaks Drive
Capitol Heights, MD 20743 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. Benjamin Nichols Jr/nephew altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 4/27/09 Brentwood, MD Ft. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iate Cause (Final Chrome Obstructive Pulmonney Disease **Physician** intron disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Huno deal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗷 No 1 □ Yes 2 🗷 No 1 ☐ Yes 9 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one within 2.

State Registrar 29b. Signature and trill

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31. Date filed (Month, Day, Year)

certifier

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32. Registrar's Signature

1328

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0055120

avenue SE Smite 310 working for De 20032

29d. Date signed (Month. Day, Year)

22 2004

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11:10 a M April Thomas Ellsworth Owens 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 118 Lafayette Drive Elkton Cecil 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **№** M 2 🗆 F 216-16-6056 87 Oct. Maryland Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director Elkton Maryland Cecil 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 118 Lafayette Drive 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14 Race - American Indian 72 hours after 1 XYes 2 ☐ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □ Yes XIX No Specify. þ Specify: White 3 Widowed 4 Divorced WW II "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aberdeen, Maryland Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flora B. Light Clinton E. Owens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and ... **ment of Health an ... **m 27 is 118 Lafayette Drive, Elkton, Maryland item 27 other t Evelyn Lynn Owens 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ortant: If i 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or Principio Cemetery 04/18/09 Perryville, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. ture of Funeral Service Licentee Perryville, Maryland 21903-0766 Approximate Interval Between Of set and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last physician pe Physician/Medical requires that the death certificate the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy õ in the past 12 months? Day Year 5 Other (specify) o. the a 1 Tyes 2 No been signed by the should be detached 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? cate has t page 2 sl autopsy performed certificate 2 □ No 1 ∐Yes 2**X**□No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2/11/No After this of funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred XX Natural 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 7+1 VA John Mulvey, M.D., Ill West High Street, Elkton, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

# **VOID**

# CERTIFICATE #

2009 - 13938

SEE

CERTIFICATE #

2009 - 15357

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Degledent's Name (First, Middle, Last) 2. Date of Death Date Month Day **Physician** Year NGELO 741 M OLL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** 1 2 M 2 □ F Months Days Hours Min. 56 Director 579-68-7051 12/15/1952 DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show Director 1X Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA Funeral 16309 Epsilon Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 

Yes 2 

No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 St Never Married 2 ☐ Married Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or i any injury or other traumatic event, If a Modical Examing 2008. Maryland 21215-0036 If Yes, Give Year or Dates 1970-1974 1 ☐ Yes 2 🖾 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor CHarles Co. Public Sch. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ulysses G. Polly Mildred Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Polly/nephew 2217 Naylor Rd. SE Washington DC 20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery April 25,2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a * nsequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Anns Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Division of Vital 1 ☐ Yes 2√€No 1 □ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident n 24 hours after death.

ne Funeral Director: A
oletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the the within 7 29b. Signature and title of certifier 29c. License number ဂ္

Registrar

State

0+1

Name and address of pe

Year)

6

31. Date filed (Month, Day,

on who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

W)44(

			1 State	laryland / Depa	artment of F			20	na	1301	n
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Dea			3. Time of Death				
þ	Physici /Medio	_	Ronald David P	HILLIPS, SR	R.		April 1	7, 2009	Year	12:55 P	М
1	Examir		4a. Facility Name (If not institution, give street and number 11022 Coffman Avenue	)	4b. City, Town, or Hagerst	r Location of Death		4c. County Wash	of Death	n	
1	Funeral Director		5. Social Security Number 220–28–3914 6. Sex 7. A	ge ( <i>In yrs. last birthday</i> ) 75 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 23	rth 9. Birthplace (State or Foreign Country) Mary Land			ign
٦	put		Usual Residence of Decedent  10a. State 10b. County	10c. City. Town or Lo	ocation			-	100	d. Inside City Lim	its
	Maryla f short led at	ŗo	Maryland Washington	Hagersto	own					1 □ Yes 21 1	
	with the	Director	10e. Street and Number 11022 Coffman Avenue		10f. Zip Code 2174	40	1	I0g. Citizen of V		y?	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 【 Married	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S _i an, Mexican, Puert Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rac Blac	e - America ek, White, et v: <b>whit</b> e	tc.	
Baltimore, Maryland 21215-0036	thin 72 hou ie. ian "natura iMedical E	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu		•	
7	led wil tygien her th nt, the	Con	0		ear man	18. Mother's Nan	o (First Middle		ilroad	<u> </u>	
land	uld be fi Jental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last)  Charles W. Phill	ips		To. Mouter's tvati		A. Smi			
lary	S P E E		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street						
e,	1 and Health em 27 ther ti		Susan E. Phillips - wife  20a. Method of Disposition	20b. Place of Dispo	2 Coffman osition (Name of	i		own, Mai	-		
mor	Pages ent of nt: If it ry or o		1 X Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	e   ·	matory or other plac wn Memori	al Apr	.1 01		-	Maryland	
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Licensee	23	2. Name and A dre	ss o Facility	Minnich				74(
Γ	ķ		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each						1	Approximate Interval Between	
6	Physician		Immediate Cause (Final disease or condition resulting in death)	CAD CAD	CKOR				ľ	Onset and Death	
	/Medical Examiner		Due to ora	s a consequence of):						•	
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of):							-
	ate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	s a consequence of):				-1			
8760,	te be e ysician e buria	dical E	d	, ,							
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Medi		2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	y			te of delivery	y Day Year	
Δ.	ires that t signed by d be detac	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause giv	ren in Part I.	23e. Did to		ribute to the	cause of death?	wn
COL	w requir s been si should	letec					24a. Was a		Were autops	sy findings availa	ole
= Re		Completed					autop: perfor 1⊡ Yes	med?_	prior to com death? 1 □ Yes 2	pletion of cause of	đ
Vita	Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?		nt 3 DOA Oth		th (Check only or				
ō	y Phys er this eral dii	7: To	27. Manner of Death 28a. Date of In	jury 28b. Time o	III 3 DOA	4 🗆 Nursing H	ome 5 Resid 28d. Describe h				
ion	Attending r death. ector: Atter by the funer	atio	1 Natural 5 Pending (Month, D 2 Accident investigation	Pay Year) Injury		Yes 2 □ No					
Division or Vital Records,		Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of it building, €	njury - At home, farm, str etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
	To the Hospital or within 24 hours affer of the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Physician: To the bes (Check only one) 2 Medical Examiner: On the basis and manner s	of examination and/or in	th occurred at the time time timestigation, in my o	me, date and place opinion, death occu	, and due to the d irred at the time, d	cause(s) and ma date and place,	anner as sta and due to	ted. the cause(s)	
	To the To the comple	Me	29b. Signature and title of certifier		29c. Licens		2	29d. Date signe	d (Month, D	ay, Year)	
8	A/A		1			018010	1 (	7/20	104		_
	10		30. Name and address of person who completed cause of 340 must. Ha	E-WD C	, Print) 21740	VAS	TOLA	DATT	A		
	Sta Regist			strar's Signature	22/2						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** APRIL 2009 LAWRENCE GARRETT PURDY JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOMERFORD HOUSE ASSISTED LIVING HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□F 217-28-5159 AUG. 1932 Director 76 18, MARYLAND Usual Residence of Decedent 10a. State WEST 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 217 No Director VIRGINIA BERKELEY FALLING WATERS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.

14. Race - American Indian 25419 172 ANTIOCH LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FORK LIFT OPERATOR TRUCK MANUFACTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 LAWRENCE GARRETT PURDY SR. CLARA MAE STINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN V. PURDY/SPOUSE 172 ANTIOCH LANE, FALLING WATERS, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 4 Donation 5 Dother (Specify STAUFFER CREMATORY 04/22/2009 FREDERICK, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signature of Buneral Service Paul M. Dean 7606 Old National Pike, Boonsboro, MD 21713 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 2☑ No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Watural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

burial-tran attending physician the as 1 use ģ the signed by t I be detach page certificate funeral director After this within 24 hours after death To the Funeral Director: filled in by

iral", or items 23a or 28a-f show Examiner must be notified at

"natural"

other traumatic event, the Medical

and Mental Hygiene.

Health tem 27 i

Department of H Important: If ite any Injury or oth

Pages 1 and 2 should be

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

or Attending

Hospital

2

death

certificate be

Certification:

Medical

State Registrar

31. Date filed (Month, Day, APR 20

29a. Certifier

(Check only one)

29b. Signature and til

Name and address

and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🗐 🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ,2009 Month Henry Coleman Pollard, Sr. 9, April 11:00 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 112 Pollard Lane Chester Queen Anne's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days 1**X** M 2 □ F 164-18-1045 86 12,1922 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Chester 11√TYes 2 □ No Oueen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Pollard Lane 21619 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Even in 5.5. Armed Forces? 1 ⊠Yes 2 □ No 1943. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates Specify Specify: 3 Widowed 4 Divorced Black 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Security Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nora Jones William Arthur Pollard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester, Maryland 21619 Ollie Pollard 112 Pollard Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 4/18/2009 Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home, Washington St. Cambridge, MD 21613 23a. Part Kenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and burial-trar attending physician as nse ξ signed I

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

10a. State

MD

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Madical Expinition must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other traumatic concerns.

**Physician** 

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Baltimore, Maryland 21215-0036

page 2 should filled in by the funeral

Division of Vital Records, P.O. Box 68760,

9 Unknown 0

spital:	1 Inpatient	2 🔲	ER/Outpatient	3 🗆 [	OOA	Other: 4	☐ Nursi
	Date of Injury (Month, Day, Ye		28b. Time of Injury			Injury at Work?	
				M		1 ☐ Yes	2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Redistrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only physician 29b. Signature/and title of certifier

6 ☐ Could not be

determined

29c. License number 4005782 29d. Date signed (Month, Day, Year) 4,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

soud man Maylano 21617

Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 3943 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April ANNA E. PERROTTA 200^{year} 8:35 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles County Nursing&Rehab. Ctr. IaPlata Charles . Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9/29/1921 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 6 Sev Days Hours 1 □ M 2 🗓 F 154-14-7043 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liujury or other traumatic event, the Modical Engineer must be notified an any lights or other traumatic event, the Modical Engineer must be notified an any lights of any once. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles La Plata 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Road 20646 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ 3 Nidowed 4 □ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fiscal Accounts Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS PELLEGRINO ဂ TERESA FRANCTA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dodie Kotzian/Daughter 5769 Linden Farm Place La Plata,MD.20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 4/27/09 | Arlington, Virginia | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Licensee 6160 Oxon Hill Rd., Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumania **Physician** day resulting in death) /Medical R) lung cancer Examiner Months Sequentially list conditions, if any loading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician a the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ 10 23d. Date of delivery 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Plabetes Mellitus prefension 1 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ LANO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
April 13th, 2009 29c. License number DU061614 13 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 1 6 2009

Ravi Sindhwani, M.D. 6 Post Office Road, Suite 101 Waldorf, Md. 20602

32. Registrar's Signature

park

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Z009 **Physician** Iris В. Payne 3:25AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice Salisbur coastal O+ the e Lake とうじゅうべいこう If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Months 1 □ M 2 🕱 F 215-04-1928 80 Director 11/04/1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits is 23a or 28a-f show must be notified at Salisbury Director Maryland Wicomico 1 ☐Yes 2 TXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Creekside Drive 21804 USA by Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status r than "natural", or items the Medical Evaminer of Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) administrative assistant legal firm permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Girlon Banks Frank B. Beach ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Creekside Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Kerford Payne/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/09 Hebron, MD Gardens 21. ** parure of Funeral Service ToTToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 A.1. Enter the disease, or complications that caused the delih. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ances 100 /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, Year) 16 Registrar

29a. Certifier

29b. Signat

amueller MD 32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician PAMALEE D. ROSS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/14/1937 7. Age (In yrs. last birthday)
71 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Hours Min PENNSY LVANIA Months Days 161-32-4424 1 □ M 2 🕽 F **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maclical Examinating must be notified at once. 1 ☐ Yes 2 ☐ No HAGERSTOWN WASHINGTON MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21740 11010 ROSEWOOD DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) LETTERKENNY (DESCOM) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY ARMY DEPOT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MABEL SINGER HARRY E. SHADLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11010 ROSEWOOD DRIVE, HAGERSTOWN, MD 21740 19a. Informant's Name/Relationship (Type. Print) DONALD J. ROSS/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition APRI 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 19, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 21. Signature of Funeral Service Licensee 327 W. KING ST., MARTINSBURG, WV 25402 leo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 XNO 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 Tyes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580 Normern 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year William Walter Rinn III 259 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 03/25/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 217-28-1525 77 Director OH Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County s 23a or 28a-f show 10d. Inside City Limits MD Director Washington Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 67 Brightwood Drive 21740 US Funeral of Health and Mental Hygiene.
item 27 is marked other than "natural", or items
other traumatic event, I'm Medical Evaluation 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 M Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. White ≥ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Sales Representative Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Walter Rinn Jr. Norinne (unk) Kidder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Lou Rinn / Wife 67 Brightwood Drive, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery 04/23/2009 | Sharpsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Julmoraus Kliseas **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-trar tending physician ar r use as the burial-Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy this certificate 2 ZNO 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဥ 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐Yes 2 ☐No illed in by the fi 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D27898 20109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST. HAGERSTOWN. 0H-7 FRANCISCO M.O 350 ANORADE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Olive Lutman Ragan 2009 /Medical April 7:00 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Elkton Care & Rehab E1kton Ceci1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 15, 1932 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1 □ M 2 🗓 F Director 212-32-4126 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County or items 23a or 28a-f show viner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Ceci1 Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1835 Frenchtown Rd. 21904 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No traumatic event, the Medical Exarþ If Yes Give Specify 3X Widowed 4 ☐ Divorced Specify: White "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 Is marked other the any Injury or other traumatic event, Inc. 90028. Customer Service Banking 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Telford Lutman, Sr. ပ္ Virginia Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Telford Lutman, Jr./Brother 4116 Walnut Ave., Carmichael, CA 95608 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04-13-2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uchago 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crulled on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final **Physician** disease or condition resulting in death) CARUNOMA /Medical Due to (or as a consequence of): Examiner PNeumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed RESPIRATORY FAILURE and Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 D Ectopic pregnancy Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ has been si e 2 should t Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 1 ☐ Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V. Naya 1 DOO 65733 HD

State Registrar NARAYANA
31. Date filed (Month, Day, Year)

APR 17

V · PULA

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible byk. Frey 6 Al Copies Are Legible.

Amend Item I Per physiology. Frey 6 Al Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11 & 16 per spouse 6894 8/6/09 dk

Reg. No.:

Reg. No.:

Reg. No.: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year APRIL Hubert Leodis Reid 200 9 Hubert-L-Reid /Medical 4a. Facility Name (If not institution, give street and number) Location of Death 4c. County of Death 4b. City, Town Examiner CIVISTAMEDICA If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) C 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Date of Birth (Month, Day, Year) Months Days Hours Min. 1X M 2□ F Yrs. 577-40-9509 Director 76 12-26-1932 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evandor invest to retified at 1, Yes 2 No **Funeral Director** MD Waldorf Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2335 Tawny Dr. 20601 US 12. Was Decedent Ever in U.S. Armed Forces? 1★□Xres 2□No If Yes, Give Year or Dates: 11. Marital Statusx Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 Never Married 2013Married 1 ☐ Yes 2√☐ No Specify: Completed by Specify: 3 Widowed - 4 Diplyorced BLACK 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Analyst 12th Department of Defense Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot Claude P. Reid ပ Ruth Reeves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 2335 Tawny Dr. Waldorf MD 20601

20c. Location - City or Town, State Amelia Reid Department of Heal Important: If item 2 any Injury or other once. ē 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimdr 1 XBurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peters, Catholic Church 4-17-09 Waldorf, MD permit. 22. Name and Address of FacilityJohn T Rhines Funeral Home LLC 21. Signature of Funeral Service Licens 3005 12th St NE Washington, DC 20017 Juan Smith 23a. Part 1. Enter the disease or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying such as cardiac or respirator arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Due Examiner 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No. g Unknown cate has been signed by page 2 should be detach Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 24 hours after death Funeral Director: 3 Sulcide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnet stated. 29a. Certifier Medical eck only within 2 29b. Sic nature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 15 Name and address of person who completed cause of death (Item 23a) Type, Prist Vd0 MOL ON 32. Registrar's Signature State APR 1 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State #8 per fh, 4/17/09 eb Amend item Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2:35 PM RIGGIN GRACE MAE 14 2009 0011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rincess Anne Somerset Manokin Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. 5/22/2 /9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 218-20-5918 81 Yrs Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location other than "natural", or Items 23a or 28a-f show went, the Indical Examination ust be motified at Maryland Crisfield Somerset 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 U.S.A. 26410 Mariners Road by Funeral and 2 should be filed within 72 hours after death lealth and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Brush Mfg. Inspector 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Littie Green John T. Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 610 9th St., SW - Washington, D.C. 20024 Philip Riggin (Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 4/17/09 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Lice Robert H. Bradshaw, 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** a/2 heemer 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify). signed by the a 9 Hipknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Zule nely 15/2 2009 DU513>9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/200

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DIVISION

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			1 _ For State Registrar	State o	f Marylan		artment of F ctificate of I		Mental		ne No. 2009	13950
	Dhi.:		Decedent's Name (First, Middle, I	.ast)					2. Date of	f Death		3. Time of Death
4	Physici /Medio		Robert G. Rowe						Apr:		8, 2009	12:50 P ^M
	Examir	er	4a. Facility Name (If not institution, g	iive street and nur	mber)		4b. City, Town, or		ath		4c. County of Deat	1
	Funeral		607 Kaywood Dr. 5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	Salisbur	If Under 24 H	rs. 8. Date of	of Birth		nplace (State or Foreign
ı	Director		173-38-2906	1 <b>⊠</b> M 2□ F	60	Yrs.	Months Days	Hours Mi	6/11	/1948	B Pen	nsylvania
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Mary Ind	tor	Maryland Wicomi	co	Sa	lisbur	V					1 X Yes 2 □ No
	or 28g	Direc	10e. Street and Number				10f. Zip Code				Citizen of What Co	untry?
	ath wi	ral	607 Kaywood Dr.				21804			US		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Exprint at rount be putified and once.	by Funeral Director	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 Married</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	Armed Fo	2 📉 No ve		Was Decedent of H fYes, specify Cuba I□Yes 2⊠No	ispanic Origin? an, Mexican, Pue Specify:	(Specify Yes o erto Rican, etc	r No- .)	14. Race - Ame Black, White	
2-0	72 hou natura	eted	15. Decedent's (Specify only highest of	Education		16a. Deced	lent's Usual Occup kind of work done o	ation	orkina	16b.	. Kind of Business/l	
21215-0036	vithin '	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Teach	DO NOT use retired	i)	oning .	ТО	aching	
<b>Q</b>	filed v Hygie other ent, II	Be Co	12 17. Father's Name (First, Middle, La			reacii	er	18. Mother's N	ame (First, Mi			
Maryland	uld be Venta Irked Itlc ev	To B	George W. Rowe					Jean C	akley			
lar∖	2 shorand I	·	19a. Informant's Name/Relationship	(Type. Print)		1	-				ty or Town, State, Z	ip Code)
e e	1 and Health em 27 ther to		Nancy Rowe/wife 20a. Method of Disposition		20h F				Date Date	<del></del>	nd 21804	Town State
μoμ	ages ent of it: If It		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State		sition (Name of natory or other place	·			lisbury,M	
Baltimore,	mit. P partme portan / Injur		21. Signature of Furr ral Service Lic		Sa.		Cremato: .Name and Addre olloway E		10/2009		I I SDUL Y / F	aryrand
ñ	an in Dear		I had to	Dla	ne C						Maryland	21804
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ecords, P.	requires that the veen signed by th hould be detache	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	derlying cause give	en in Part I.				the cause of death?
ľ	The lar	Completed		- 142.			. ************************************		-   8	Was an autopsy performed a	prior to o	topsy findings available ompletion of cause of
VIII VIII	iding Physician: The th. The this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hamitale			Louis	26. Place of D				
0	Phys this al dii	<u>1.</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 🗆 I	npatient 2   of Injury	ER/Outpatien	t 3 DOA Othe	4 L Nursing			e 6 □Other (Specialist of the first occurred)	eify)
VISION	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mont	th, Day, Year)	Injury	Work	ໃ?ົົ Yes 2∐No	200. 2000	100 11000 111	nary occurred	
DIVIS	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not determine	be 28e. Place buildii	of Injury - At hong, etc. (Specil	ome, farm, stre	eet, factory, office		28f. Locati City o.	on (Street r Town, St	and Number or Ru ate)	ral Route Number,
	ne Hospi n 24 hour ne Funer bletely fill	Medical	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	aminer: On the ba	best of my kno asis of examina ner stated.	wiedge, death ation and/or in	occurred at the tirvestigation, in my o	ne, date and pla pinion, death oc	ce, and due to curred at the t	the cause ime, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	~	\		29c. License	e number		29d. I	Date signed (Month	, Day, Year)
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	aluc		30. Name and address of person wh		e of death (Iter		Parrae	_	0	5.1		ws 2121
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa		·	- W	-V.	~ ~ \	1122914	all !
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Pasquale Rocco april 12, 2009 12:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 220 Sandy Bottom Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 077-16-7397 89 Director 2/07/1919 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Department of Health and Mental rygjene. Important: yor Items 23a or 28a-f shov Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, If a Medical Evander out to notified any Injury or other traumatic event, If a Medical Evander out to notified any Injury or other traumatic event, If a Medical Evander of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second Maryland Wicomico Salisbury 1 Tx Yes 2 □ No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21804 USA 220 Sandy Bottom Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 XYes 2 □ No If Yes, Give Army Year or Dates: Army 1 ☐ Never Married 2 X Married 1 □Yes 2 X No Specify Specify: white <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical engineer IBM 12 should be filed wi th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Rocco Sarnesa Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7420 Flint Hill Rd., Owings, MD 20736 Bruce Rocco/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/16/09 Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Fureral Service Licenses Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ile disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to trained at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con jequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ~~ Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy
performed

1 Yes 2 No Fra 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001

D.

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

29a. Certifier

Medical

3altimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of the Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1) 20 45005

29d. Date signed (Month, Day, Year)

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			For State Registrar	State of M	laryland /		artment o rtificate d		d Mental H	ygien Reg. N	2000	13952
	Physic		1. Decedent's Name (First, Middle, La Merrill Lee	*	sh Jr.				2. Date of D Month	eath D	yay Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, giv			enter		n, or Location of Do	eath		c. County of Deat	h .
	Funeral Director		5. Social Security Number 6. 8	Sex 7. A	ge (In yrs. last		If Under 1 Ye Months Da		8. Date of B (Month, L)	irth Day, Year		hplace (State or Foreign untry) cyland
	Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicom:	ico	10c. City, To	wn or Lo						10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	th with the 23a or 28a ast be noti	Funeral Director	10e. Street and Number 310 Pine Way		<u> </u>		10f. Zip Cod		-	10g. C	Citizen of What Co	untry?
9800	2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?   No	[	Was Decedent of Yes, specify C		(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	mit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natur injury or other traumatic event, the Medical.	Completed by	15. Decedent's E. (Specify only highest grades) Elementary/Secondary (0-12)	lucation ide completed) College (1-4or		(Give life. L	dent's Usual Oc kind of work do DO NOT use ret .ce offi	ne during most of v ired)	working	1	Kind of Business/I W enforc	
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, Mary	and 2 shou ealth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Gloria Ann Reddis		1	9b. Mailin 310	g Address (Stre Pine Wa	eet and Number or Ny, Salis	Rural Route Numb	ber, City 218	or Town, State, Z	ip Code)
imore	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		Sp <b>r</b> ir	of Dispos tery, crea ighil dens	sition (Name of natory or other p Memor	olace)	Date 16/09	1	Location - City or T	
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and the second	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. AMY	oldusi	2	er the mode of o	dying, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
-green	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. END	STAG 3 a consequence	EL	ENAL	DISEASE.				
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). Box 687	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the bage 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		e of pregnancy 2  ☐ Fetal dea at time of death		Ectopic pregna				23d. Date of deli Month	very Day Year
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of Vital Records,	The law requir ate has been s age 2 should l	Completed by							24a. Was	s an opsy ormed?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
/ita	Physician; The rthis certificate hiral director, page	Be C	25. Was case referred to medical examiner?					26. Place of D	Death (Check only		o I I I les	140
of \	S = 5	۵,	1 ☐ Yes Ž-☐ No		ent 2 ER/0		3 DOA		Home 5 ☐ Res	idence	6 ☐ Other (Spec	ify)
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	the Hos hin 24 ho the Fune	Medical		niner: On the basis of and manner st	ot examination a	ge, death and/or inv	estigation, in m	y opinion, death o	ace, and due to the courred at the time	e cause( , date an	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Ň	29b. Signature and title of certifier					3199.			ate signed (Month	, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

906ESH VOHRA MD. 100. E. CARROLL ST. Shlishury Md. 21801

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMFND#21perFH, 4-16-09, BMW, MoCo Certificate of Death Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Sour 2009 /Medical 4a. Facility Name (If not institution, give 4c. County of Deg street and number) Examiner Be Durbar ties Va if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Sept. 5, **Funeral** Days Hours Year, 2□ F t**y**□ M 57 1951 Washington D.C. Director 225-66-2419 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. inside City Limits Director Virginia Fairfax Springfield 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ns 23a or must be r 7421 Brian Run Court 22153 U.S.A. Funeral ral", or items ? Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ Specify: White 3 Widowed 4 Divorced 'natural", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Architect permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isaiah Henry Sourbeer ၉ Jean Beveridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meg Sourbeer, Spouse 7421 Brian Run Court, Springfield, Va. 22153 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 4 Donation 5 Dother (Specify) 4/11/2009Falls Church, Virginia 22. Name and Address of Facility Everly Funeral Home 21. Sign Maxwell #0374 Part . Antender disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or regulatory arrest, shock or heart failure. List only one cause on each line. 10565 Main St. Fairfax, Virginia 22030 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 50 /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or: Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 0500 2. Accident Mar 28 3009 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 4 Homicide Hospital or 29a. Certifier Medical (Check only one) To the h and manner stated. ionature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mon me 2121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mooms CY 31. Date filed (Month, Day, Year) Registrar's Signature State 16

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar AMEND#25 per MD, 4-16-09, BWI, MOO Registrar AMEND#25 per MD, 4/16/09, BWI, MOO Reg. No. Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7009 **Physician** Month reeman Pri /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 XM 2 □ F Yrs 70 Director 213-38-4630 08/25/1938 Washington D.C. Usual Residence of Decedent with the Maryland 10a, State 10h. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Evaminer must be notified at Director 1 XYes 2 □ No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20877 United States 16 Russell Avenue death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify Specify: r than "natural", the Medical Eva 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Computer Programmer IBM 27 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Freeman W. Sharp Marjorie Stringham ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nanci P. Sharp (Wife) 16 Russell Avenue Gaithersburg, MD. 20877 Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o
once. April 13 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2009 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** atheroscelont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Ves 2 this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No ၉ 1 ☐ Yes 2 X ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

30. Name and address of person

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Vear Month **Physician** 7:12 Ray Franklin Swope 2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1X M 2□ F Months Days Virginia Sept.30,1929 West Director 218-24-7708 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Boonsboro Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 USA Items 23a 7911 Sharpsburg Pike Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XXIo Saltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: Specify: Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 5 Construction Brick Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Lottie Breeden Samuel Franklin ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s. Department of Health ar Important: If Item 27 is any injury or other trau. Elaine Swope - Wife 7911 Sharpsburg Pike Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Salem Evang. Luth. Ch.Cem. April 21,2009 Boonsboro, Maryland 4 ☐ Donation 5 Other (Specify) Caborned Aftenser Fadlity Home, P.A. 21. Sign ture of Fund 425 S. Conococheague St.Williamsport, MD 21795 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cerebon Ascular ute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Quality (or as a consequence of) Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.0. the 9 Unknown cate has been signed by to page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hisease certificate has autopsy performed 2 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 3 NK 2 .ER/Outpatient 3 DOA 1 ☐ Yes 14 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, Street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛨 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State 31. Date f

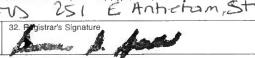
31. Date filed (Month, Day, Year)

APR 2.1

UDITH MEADUA

aous 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



162588

2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

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			For State Of Maryland / L State Registrar	Certificate of Death	Reg. 1										
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death									
	/Medic		LEONARD EARL SMITH	4h. City Tayun and continue of Dooth		15 2009 12:35 ^A M									
	Examin	er	4a. Facility Name (If not institution, give street and number)  THE HEARTLAND HOUSE	4b. City, Town, or Location of Death  GRASONVILLE		QUEEN ANNE S									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Yea	•									
	Director		217-07-7985	Yrs.	AUG. 17, 1	1916 MARYLAND									
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits									
	Mary a-f sh	tor	MD QUEEN ANNE GRAS	ONVILLE		1 □ Yes 2 X No									
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?									
	ath wi	Funeral	3925 MAIN STREET	21638	-14 - W N -	USA									
	ter de items	Fune	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - American Indian, Black, White, etc.									
036	urs af	þ	3 X Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: WHITE									
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show officel Exprimer must be routified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b.	Kind of Business/Industry									
121	be filed within 72 ho ital Hygiene. id other than "natui event, ine modical	dm	Elementary/Secondary (0-12) College (1-4or 5+)	OWNER/OPERATOR		ENERAL STORE									
	e filed val Hygie other i		17. Father's Name (First, Middle, Last)		(First, Middle, Maid										
lan	uld be f Mental I arked of atic eve	To Be	EARL H. SMITH	HELE	EN SABINS										
Maryland	and s mid		19a. Informant's Name/Relationship (Type. Print)	. Mailing Address (Street and Number or Rura	l Route Number, Cit	ry or Town, State, Zip Code)									
	1 and 2 Health em 27 i			O CARMICHAEL COURT, C											
ore			1 ABurial 2 Cremation 3 Chemoval from State	ry, crematory or other place)		Location - City or Town, State									
Baltimore,			4 □ Donation 5 □ Other (Specify) WOUDLA  21. Signature observational Service □ Senses	WN MEMORIAL PARK 4-2  22. Name and Address of Facility		CASTON, MD 21601									
Ba	permi Depar Impor any Ir		PL ALL	FELLOWS, HELFENBEIN & 408 S. LIBERTY ST.,	CENTREVIL	UNERAL HOME, P.A. LE, MD 21617									
			23a. Popt 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final												
	Physician		Immediate Cause (Fina disease or condition resulting in death)			8 years									
4	/Medical Examiner	Due to (or as a consequence of):													
	D +	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	of):											
	ecute and transi	Examin	that initiated events	of).											
68760,	tificate be executed og physician and as the burial-transit		resulting in death) Last Due to (or as a consequence	01).											
687	tificate ng phys as the	<b>ledical</b>	d												
Вох	eath cert attending for use a	M/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery									
О. В	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		Month Day Year									
σ.	that the dended by the a		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?									
of Vital Records,	w requires that s been signed b s should be deta	ed by	Chronic obstructive pulmonary	disease	1 ☐ Yes	2 No 3 Probably 4 Unknown									
900	e law rec has bee e 2 shor	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of									
Œ.	The l	Som			performed 1 □ Yes 2 □	?/ death?									
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referre to medical examiner?	26. Place of Death											
of	Phys this al dir	<u>و</u>	27. Manuer of Death 28a. Date of Injury 28b.	A Nuising 1 or	me 5 Residence	e 6 Other (Specify)									
ion	Attending r death. ector; After by the funer	atior	1 ✓ Natural 5 □ Pending (Month, Ďay, Year) 2 □ Accident investigation	injury Work? M 1 □Yes 2 □No											
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)									
Ω	pital c	Cel	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place	and due to the cause	e(s) and manner as stated									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	ledical	(Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.												
	To the To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)									
	1.1		Magazi	(True Print)	H	701 13, 2001									
	UB		30. Name and address of person who completed cause of death (Item 23a)  Daniel J. Kunick, M.D. 115 Sailit	Prive, Juite E St	eversville,	MD 21666									
	Sta Registi		31. Date filed (Month, Pay Year) 32. Registrar's Signature	(Type, Print)  - Prive, Juite E Ste											

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			For	Stat	e of Ma	aryland				ealth and N	Mental Hyตุ	giene	0000	\ I	0.0	pro org
			- State Registrar				Cer	tificate	of D	eath		Reg. No.	2005		39	21
	Physicia	ın	Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	Day			Time of I	Death
	/Medic		May Elizabeth		-	1		41 07 7	F	and Death	April 1		2009 County of Dea		:05 a	a "'
	Examin	er	4a. Facility Name (If not institution					4b. City, 1		ocation of Death nardtown		40.	St. N		C	
	Funeral		St. Mary's Nur  5. Social Security Number	6. Sex		e (In yrs. la	ast birthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Birt	٦ , ,	9 B	rthplace		Foreign
	Director		579-01-0791	1 □ M 2 🖁	F	96	Yrs.	Months	Days	Hours Min.	(Month, Da)	, <i>Year)</i> .912	Was	Sountry) shing	ton	, DC
	p.		Usual Residence of Decedent				. T	4:						104 1	nside Cit	u Limito
	arylar shov	5	10a. State 10b. County				, Town or Lo								□Yes	<b>'</b>
	28a-f	Directo	Maryland St.  10e. Street and Number	Mary's	3	I	Leonar	dtown 10f. Zip	Code			10a. Cit	tizen of What C			
	with ya or		42035 White P	oint Do	oob E	bood.				650			USA			
	ms 2%	Funeral	11. Marital Status	12. Was	Decedent	Ever in U.S	3. 13. V	Vas Deced		panic Origin? (S _I , Mexican, Puerto	pecify Yes or No-		14. Race - Am	nerican In	dian,	
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7	E ₽ E	duc	Elementary/Secondary (0-12)	Colle	ege (1-4or s	5+)	_	ecret				Е	ducatio	on		
ק ס	al Hygi other vent,	a l	17. Father's Name (First, Middle,	Last)						18. Mother's Nam	ne (First, Middle,	Maiden	Surname)		-	
<u>a</u>	Ald be Alental rked of tic ever	OB	William H.	Lo	ott					Elaine	Ful	l1er	•			
Maryland	nd 2 should be filed lith and Mental Hygi 27 Is marked other r traumatic event, I		19a. Informant's Name/Relations	hip (Type. Prin	t)	-	19b. Mailin	g Address	(Street ar	nd Number or Ru	ral Route Numbe	r, City o	or Town, State	Zip Cod	e)	
	and 2 lealth a m 27 ls her tra		Liz Sherman/Da	ughter						ey Cliff						36
Ĕ	ot ite		20a. Method of Disposition  **Disposition**  Cremation**	3 □ Removal	from State	CE	lace of Dispo	natory or ot	her place,		Date		ocation - City o			
altimore,	t. Pag tmen tant: ijury		4 ☐ Donation 5 ☐ Other (S	pecify)		Tr	inity				/2009		dorf, l			
g	permit. Page Department ( Important: If any Injury or once.		21. Signature of Funeral Service  Kyle Simons	Licensee M0120	6/1	>	~	. Name and 2955		ywood Rd	insfield., Leona					Α.
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications only one cause	that cause	d the death	. Do not ent	er the mode	e of dying	, such as cardiac	or respiratory ar	rest,		Inte	roximate rval Bety	veen
	Physician		Immediate Cause (Final disease or condition		_		onary	Event							et and D nute:	
	/Medical Examiner		resulting in death)	D. D.	ue to (or as	-	•									
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	nsit	mine	cause. Enter Underlying Cause (Disease or injury	<b>S</b>		o contacte	orise org									
<u>_</u>	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c	ue to (or as	a consequ	ence of):							† <del></del>		
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õ	ng ph as th	ĕ	IF FEMALE:										22.00			
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Vital Records,	uires n sign ld be	d by	Hypertension	, Conge	estive	e Hear	rt Fai	lure			1 🗆 Y	es 2	□ No 3□	Probably	4 🕿 L	Inknown
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ā	yslcian: The lis certificate hi director, page	a	25. Was case referred to medica							26. Place of Dea			7			
o •	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 <b>T</b> No	Hospital:			ER/Outpatier			4 Mursing n	ome 5 Resid	lence	6 □Other (S _i	ecify)		
Ē	ing P	on:	27. Manner of Death 1     Natural 5 □ Pendir		Date of Inj (Month, Da	ury a <i>y, Year)</i>	28b. Time of Injury		8c. Injury Work?		28d. Describe h	ow inju	ry occurred			
<u> </u>	tendi leath. tor: A the fu	cati	2 ☐ Accident investi	gation	Diago of la		form str	M		es 2 □No	29f Logotion (	244	and Alexandra and	Down I Do	uto Alcum	har
DIVISION	lor At after c Direc	ertification:	4 ☐ Homicide determ	nined 26e.	building, e	tc. (Specify	me, farm, str	eet, lactory,	, once		28f. Location (5 City or Tov	vn, State	e)	nurar no	ute rvann	Der,
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, t	ledical C	(Check only 2 Medical	Examiner: Or	the basis	of examinat				ne, date and place pinion, death occu						)
	To the I within 2 To the I complet	Med	one) 29b. Signature and title of pertific		manner si	ated.	.1/	290	. License	number		29d. Da	ate signed (Mo	nth, Day,	Year)	
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/	1000		30. Name and address of person James P. Jan	boe, M	/				otch	Rd., Ho	11ywood	, MD	20636			
	Sta	te	31. Date filed (Month Day, Year,	-	60 0	1 0:						,				
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P.O. Box 68760, Division or Vital Records,

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State Registrar

DHMH 17 Rev 1/2001

52 WATER 31. Date filed (Month, Day,

29b. Signature and title of certific

THURMONT, ST. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

reserve

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\underline{A}^{\mathsf{M}}$ April 2009 9 11:45 Bettymae A. Sine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Northampton Manor Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Jan. 7, 19 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🖾 F 74 1935 Washington D.C. Director 217-28-6736 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Examinating the motified at 1 ☐ Yes 2X No Director Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10e. Street and Number death with 20905 United States 6 Redgate Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 ☐ Yes 2 🏖 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2. No Specity Specify: ð 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Everhart Charles W. Sine ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any injury or other traun once. Redgate Court, Silver Spring, Maryland 20905 Virginia Hedges/ Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Stauffer Crematory Inc 4/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature Ineral Service License 621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEARS CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) ed by the a detached f 9 Hlnknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No spital or Attendl nours after death. neral Director; A / filled in by the fu 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staged. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 21793 RICHARD WALKERSVILLE

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

PO Bux

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** April 11, 1:05 James B. Stockett, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Edgewater 3712 6th Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland Date of Birth (Month, Day, Year) 4/14/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2□ F Months Days Hours 74 Director 220-28-7211 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wadical Evention of the particle of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the secon 1 □Yes 2 No Director Anne Arundel Edgewater Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and 2 should be filed within 72 hours after death with teath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or : 21037 USA 3712 6th Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7th Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Vernon Stockett Anna Helen Armiger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 i 3712 6th Avenue, Edgewater, MD 21037 Gary Stockett/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 permit. Pages:
Department of I
Important: If ite
any injury or o
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/15/2009 Kalas Crematory Edgewater, MD 21. Signature of Funeral Service I censes 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** ung VECKE Lancer disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
To the Furneral Director: After this certificate has been signed by the attending physicial completely filled in by the tuneral director, page 2 should be detached for use as the burn completely filled in by the tuneral director, page 2 should be detached for use as the burn. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 100 2 L No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

redical Parkingy Suite 100 Annapoly MD21401

		State of Maryland /	Department of Health and M	lental Hygiene	
			Certificate of Death	Reg. No.	2009 13951
	Physician	1. Decedent's Name (First, Middle, Last)  JOHN LAWRENCE SOMER	S, JR.	2. Dete of Death Same	Year
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	iter death with the Maryland ritems 23a or 28s-f show finer must be notified at	4770 Poplar Street	21817		U.S.A.
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Ĕ	nit. Peges artment of I ortant: If its injury or o	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)	dge Memorial Park	1/18/09 Cr:	isfield, MD
Dalifillion	permit. Peges 1 and Department of Health Important: If Item 27 any injury or other ti once.	21. Signature of Poneral Service Licenson	22. Name and Address of Facility Bradshaw & Sons Fur	neral Home	
_	20200	Robert H. Bradshaw, J.	306 W. Main St 0	Crisfield, N	MD 21817
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Ye ar Month 23 Day **Physician** Shafferman 04 2208 Gerald Ralph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 □ M 2 □ F Mar 17, 1935 Director 234-52-7318 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County WV Mineral Ridgeley 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26753 Route 1 Box 228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □ Xo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Ye ar or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad carman/wreck master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Shafferman Mary Susan DeMoss Shafferman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise Shafferman WV 26753 Route 1 Box 228 Ridgeley wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Israel Cemetery 4/27/20d9 WV Grafton 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fun Tal Service Ocensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications a shock, or heart failure. List only one couse Immediate Cruse (Fin I disease or o'ndition resulting in reath) Approximate Interval Between Onset and Death hat,caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one couse on each line. SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner KETROPERITONEAL AB SCESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 DUnknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has After this certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after com. Af he Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Pex Year)

OLAIDE

ress of person who completed cause of death (Item 23a) (Type, Print)

900

32. Resistrar's Signature

AJAYI, M.O

D0066606

Drive Cumberland, MD

09

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year April 12, John Tremb1y 7:58 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 800 Bridgeport Way Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2/17/1924 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia Months Days Hours Min. 1 X M 2 □ F 233-30-5891 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Maryland Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bridgeport Way 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐Yes 2 No If Yes, Give Year or Dates: W.W. II Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Research Glass Technologist Glass Blowing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John W. Trembly Dollie Phares 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann V. Trembly/ Wife 800 Bridgeport Way, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 4/16/09 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 6 Mala 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONAR disease or condition resulting in death) VROS Due to (or as a consequence of) Sequentially list conditions, if am leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any Injury or other traumatic event, I'll. 100. Once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examinar must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by

sician and burial-trans attending physician for use as the buria signed by the a page 2 should has certificate director. this filled in by the funeral

Physician: The law requires that the death certificate be executed

Hospital or Attending after death

Division of Vital Records, P.O. Box 68760,

Com			autopsy performed? death?  1 \( \text{Yes} \) 2 \( \text{No} \)  1 \( \text{Yes} \) 2 \( \text{No} \)
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 A Residence 6 □ Other (Specify)
rtification:	27. Manner of Death Natural 5 Pending Accident investigation	(Month, Day, Year) Injury Work?  I □ Yes 2 □ No	8d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier (Check only one) Certifying Place   Check only one)	<b>sysician:</b> To the best of my knowledge, death occurred at the time, date and place, a <b>niner:</b> On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated.  ed at the time, date and place, and due to the cause(s)

24 hours a сопретель

To the I within 2 To the I

Registrar

1003637

29c. License number

2009

21037

Name and address of person who completed cause of death (Item 23a) (Type, Print)

3169 Braveton St 201 AYMOND NFER MO

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

nd	Mental	Hygiene 2	n	n	9	1	3	9	6	4
		Reg. No.			-				_	

Physiciar /Medica Examine	
Funeral	
Funeral	

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evaniner rust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar				Ce	ertificate d	of Deat	th		Reg. N		0 )	100	707
		1. Decedent's Name (First, Mide	dle, La	st)						2. Date of				3. Time of D	eath
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I, or	þ	3 □ Widowed 4 □ Divorce		If Yes, G Year or D	ive		1 □Yes 2 🔀	No Spec	cify:			Specify	y: B1	āck	
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ter th	<u> </u>	27 Manner of Death		28a. Date	of Injury oth, Day, Year)	28b. Time Injury	of 28c.	njury at Vork?		28d. Descri	be how inj	ury occur	red		
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by th	iţi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined	28e. Flace	e of Injury - At I	nome, farm, s	treet, factory, offi	ce					per or Rura	al Route Numb	er,
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nera / fille							th occurred at th								
e Fu	Medical	(Check only 2 Medica one)	I Exar	miner: On the I and mar	basis of examir nner stated.	nation and/or	investigation, in r	ny opinion,	death occur	rred at the tir	ne, date a	nd place,	and due to	o the cause(s)	
To the Principal Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Me	29b. Signature and title of certifi	er				29c. Lic	ense numb	er		29d. D	ate signe	d (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

Box 68760.

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			For State Registrar	State of Maryland		artment of		and Mer		iene g. No. 200	9   391	66
	Physicia	an	Decedent's Name (First, Middle, Last)	Rose WEINS		inoato o	- Dodin		Date of Death Month	n Day Yea		
	/Medic Examin		4a. Facility Name (If not institution, give  Bedford Court    5. Social Security Number   6. Se	street and number)		4b. City, Town, Silv	er Spr	of Death ring	Date of Birth	5, 2009 4c. County of De Montgo		
ı,	Funeral Director			M 2 M F 100	Yrs.	Months Days		Min. Ma	(Month, Day, rch 12	2, 1909 Ri	Country)	
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	th with the 23a or 26 ust be no	Funeral Director	3701 Internationa	l Drive		10f. Zip Code	2090	)6	10	og. Citizen of What of Inited Sta	Country?	
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural".	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:		Vas Decedent of fYes, specify Cu I □Yes 2 🛣 No			Yes or No- an, etc.)	Black, Wi	merican Indian, nite, etc. white	
Maryland 21215-0036	d within 72 ho giene. er than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occ kind of work don DO NOT use retii	upation e during most red)	t of working		Garment		
land	uld be filed Aental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Isaac Shapiro					er's Name <i>(Fil</i> I <b>nknown</b>		faiden Surname)		
S	as 1 and 2 should b of Health and Ment item 27 is marked rother traumatic e		19a. Informant's Name/Relationship (7) Marvin Weinstein,		19b. Mailin	g Address <i>(Stree</i> Durham R	oad, E	er or Rural Ro ast Me	oute Number, adow,	City or Town, State	, Zip Code)	
Baltimore,	Page Trent ant: It		20a. Method of Disposition  1 A Burial 2 Cremation 3 A F 4 Donation 5 Other (Specify)  21. Signatur Funeral Services income	removal from State	Monte	sition (Name of natory or other pl Fiore Ce	metery		//09 F	armingda		
g	permit, Departr Importa any inji		23a. Part1. Enter the disease, or compl		2		011 St.	., NW,	Washi	ngton, DC	20012 Approximate	
	Physician /Medical Examiner	iner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Cerebrovasc  Due to (or as a consequence)  Due to (or as a consequence)	ular A		ying, odon do	cardiac of re-	spiratory and	,	Interval Betweer 7 Orset and Death 7 DayS	h h
9/60,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent.	ence of):							
O. Box 6	the death certific y the attending p ched for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnal				23d. Date of o	delivery Day Year	
ds, P.	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions co	ntributing to death but not resu	lting in the ur	nderlying cause g	jiven in Part I.		23e. Did tob	V/	to the cause of death	
II Kecords,	aw as b 2 st	Completed	Hypertension						24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
r Vital	iyslclan: is certifi director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3□ DOA O	thor:	of Death (Clursing Home		nce 6 🗆 Other <i>(S</i> .	pecify)	
lon of	nding Ph ath. r: After th te funeral	ation: 1	27. Mapner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	W		28d.		w injury occurred		
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f.	Location (Str City or Town,	eet and Number or , State)	Rural Route Number,	
	he Hospit in 24 hour he Funera pletely filli	Medical (	29a. Certifier (Check only one)  1	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the vestigation, in my	time, date an opinion, dea	nd place, and ath occurred a	due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
h	ter in the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the seco	Σ	29b. Signature and title of pertifier	~ m		29c. Lice	nse number D 187	26		od. Date signed (Mo April 15,		
			30 Name and address of person who con Arthur Schoengold	ompleted cause of death (Item	23a) (Type, I Prince	PrimPhilip	Drive	, 01ne	y, MD	20832		
	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 16 200	32 Registrar's Signat	. pa	KI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Florence Wildner M 33 /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 2,1919 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Yrs. July Director 89 <u>067-12-2652</u> Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Marical Examinatingst be notified at Directo 1 □ Yes 2√2√No Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16606 Mosby Drive 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 <u></u>Yes **XX**No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3€Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Paul Migge Elizabeth Rosanna Anderson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health a Important: If item 27 is any injury or other trau Lois W. Schultz - Daughter 16606 Mosby Drive Williamsport, Maryland 21795 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park April 22,2009 Hagerstown, Maryland ature of Juneral Service OSBOTAE AFUMEFETTY Home, P.A. 425 S. Conococheague St. Williamsport, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Kespinahox /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) the ☐Yes 2 ☐Ne 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ₫ 1 □ Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has l 24a. Was an certificate 2 No 1□Yes 2 100 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division 1 Kill Jural 5 Pending investigation thours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 62588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hope show NOH-L Anheranst. MBAOUA 251 HTIQUE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

TLA

32. Registrar's Signature

Months

10f. Zip Code

Certificate of Death

Physician
/Medical
Examiner

Decedent's Name (First, Middle, Last) FRANKLIN FIELD WILLIS

5. Social Security Number

218-34-9844

2. Date of Death APRIL

3. Time of Death

Facility Name (If not institution, give street and number) 2652 COX NECK ROAD

10b. County

1 X M 2 □ F

OUEEN ANNE'S

4b. City. Town, or Location of Death CHESTER

Days

5 2009 16, 4c. County of Death

8:00 AM

**Funeral** Director

show

d other than "natural", or items 23a or 28a-f slevent, the Medical Exeminar, past by notified

ō

the Maryland

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a, State Director MARYLAND 10e. Street and Numbe Funeral 11. Marital Status þ Completed Department of Health and Mental Hygien. Important: If item 27 is marked other than any injury or other traumatic event. Be ပ

10c. City, Town or Location

7. Age (In yrs. last birthday)

13,1938 AUGUST

9. Birthplace (State or Foreign MARYLAND

10d. Inside City Limits

1 ☐ Yes 2X No

CHESTER

10g. Citizen of What Country?

USA

Specify:

2652 COX NECK ROAD

1 Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 1 Yes 2 K If Yes, Give Year or Dates:

College (1-4or 5+)

70

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,

14. Race - American Indian, Black, White, etc.

WHITE

QUEEN ANNE'S

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

GROCERY STORE CLERK

1 ☐Yes 2X No Specify:

FOOD INDUSTRY

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) HELEN MARIAN FIELD

WILLIAM ALLEN WILLIS 19a. Informant's Name/Relationship (Type. Print)

21619

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

CRAIG WILLIS/SON 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place Date

23823 MOUNT MISERY ROAD, ST. MICHAELS, MD 21663 20c. Location - City or Town, State

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

WOODLAWN MEMORIAL PARK APRIL 21

EASTON, MARYLAND

21. Signature of Fundal Service License

2009 22. Name and Address of Facili

FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619

Physician /Medical Examiner

burial-tran

the. attending pl

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page 2 should

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certificate

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After t

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filled in by

24 hours after death. Funeral Director: ₽

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Hospital or Attending

Physician/Medical

2

Completed

Be

Certification: To

Medical

law requires that the death certificate be execu

Box 68760.

P.0.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

METASTATIC MELANOMA Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy Live birth 2 Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

HYPERTENSION

autopsy perform 1 ∐Yes 2 XX No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical 1 ∐Yes 2 XX No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 28d. Describe how injury occurred

2 Accident 3 Suicide 4 Homicide

27. Manner of Death

1 Natural

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35048

29b. Signature and title of certifier

4/16/09

30. Name and address of person who completed cause of death (Item 33a) (Type, Prin

629 RAILROAD AVENUE, CENTREVILLE, MARYLAND 21617 ERIC CIGANEK, M.D.,

Registrar

31. Date filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 10:55PM Η. Weber 2009 Arthur 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY WICOMICO Hospice at the hake 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. 1 X M 2 □ F Months Days Hours 80 9-15-1928 480-34-2580 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 2906 Merritt Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 195 If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1951-1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: White Specify: 3 Widowed 4 Divorced 1953 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Theodore Weber Anna Halder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna Weber - Wife 2906 Merritt Mill Road, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gds 4-18-2009 | Hebron, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death mmediate Cause (Final Igila disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Funeral Director

<u>ک</u>

Completed

Be 2

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Evarinter must be notified an once.

1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

Pages '

ltimore, Maryland 21215-0036

death with the Maryland

and burial-tran attending physician for use as the page 2 should be has certificate

law requires that the death certificate be executed

Examiner Be

Physician/Medical ۾ Completed

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The After this 24 hours a npletely within 2 To the I

1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 21 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year,

23a) (Type, Print)

State Registrar 29b. Signatu

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For	State of Ma	arylanc		artment of I		Mental Hy	giene		
		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	2009	13970
Physici	an	Decedent's Name (First, Middle, Lager)	,					Date of De     Month	Day	Year	3. Time of Death
/Medic		William George						Apri1		009	7:41 p M
Examin	er	4a. Facility Name (If not institution, gi	· ·	ı		7.	or Location of Dea		1	ounty of Death	
		5. Social Security Number 6.			ná bináh alosci	If Under 1 Year	Frederic			lvert	Tlans (Ctata as Familia
Funeral Director			Sex 1X M 2 □ F	e (In yrs. Ia <b>66</b>	Yrs.	Months Days	Hours Min		y, Year)	Cou	place (State or Foreign ntry) nsylvania
land ow		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
he Mary 28a-f sh	ector	Maryland Charles	3	Hugh	esvi1						1 □Yes 2 <b>X</b> No
23a or 2	Funeral Directo	10e. Street and Number 6995 Orchard Vie	w Lane			10f. Zip Code <b>20637</b>			USA	en of What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified alonge.	þ	11. Marital Status  1 Never Married X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		. Race - Ameri Black, White pecify:	can Indian, etc <b>hite</b>
n 72 ho n"natui kedical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind	of Business/Ir	ndustry
d withi	Com	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Chief	Warrant	Officer			U.S. Na	vy
uld be file Mental H) arked oth atic event	To Be	17. Father's Name (First, Middle, Last William Harry Ye	ager				18. Mother's Na Cather	me (First, Middle ine Eliz	Maiden Si abeth	Graham	1
alth and 2 sho		19a. Informant's Name/Relationship Arleen Yeager/Wi				ng Address <i>(Street</i> <b>Orchard</b>					
Pages 1 a ent of He nt: If item y or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		ce	meterv. crei	osition (Name of matory or other place 1d-Echol:	c Crom	Apri1 25, 2009		ation - City or To rlotte	own, State <b>Hall, MD</b>
permit. P Departm Importar any Injur		21. Signature of Funeral Service Lice	7 .	0817		2. Name and Address	ess of Facility <b>B</b> 1	rinsfiel			
		23a. Part1, Enter the disease, or con shock, or heart failure. List only	ope cause on each lin	the death.	Do not en	ter the mode of dyi	ng, such as cardia	ıc or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Acute G	angre		Choleyst:	itis				Onset and Death
/Medical Examiner		Toodking in dodkin	ence of): <b>11ati</b>	on							
pa tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a conseque							,	
execute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a conseque	ence of):							
icate be executed physician and the burial-transit	dical E										
ertific ding p	•	IF FEMALE:	OO Kuna autooma								
at the death certifi by the attending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23	23d. Date of delivery Month Day Year	
ires that t signed by d be detac		Part II. Other significant conditions	contributing to death be	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
w requires s been sign should be	ed by	Hypertension						1 🗆	Yes 2□	No 3∏ Pro	bably 4 Unknown
The la ate has page 2	Completed	Hperlipidemia						24a. Was autoj perfo 1 ∐Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
hystcian: his certific I director,	Be (	25. Was case referred to medical examiner?						ath (Check only o	ne)		
hysl this c	은	1 Yes 2 No	Hospital:			nt 3 DOA Oth	4 LI Nursing I	Home 5 ☐ Resi			fy)
ending Physath.  or: After thin the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the	ation:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio			28b. Time o Injury	Wor	ryat rk? ÌYes 2 □ No	28d. Describe	how injury (	occurred	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner sta	t examination	ledge, deat on and/or in	h occurred at the ti	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	nd manner as lace, and due t	stated. to the caus <i>e</i> (s)
17	M	29b. Signature and title of partifier	e M	D		29c. Licens	se number 54720		29d. Date	signed (Month,	Day, Year) 2009
10,0	ŀ	30. Name and address of person who	completed cause of d	eath (Item :	23a) (Type.	Print)			•	-	

State Registrar 31. Date filed (Month, Day, Year) APR 2 4 2009

Oluseun Sowemimo, MD P.O. Box 1663, Solomons Island Road, Suite 2100 Solomons, MD 20688 32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 24, 2009 April

Physician /Medical **Examiner** 

**Funeral** Director

show r than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, Its IM.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

 or Attending Physician: The law requires that the death certificate be executed
after death.
 Director: After this certificate has been signed by the attending physician and Box 68760, P.O. Division of Vital Records, the 1 filled in by To the Hospital o within 24 hours af To the Funeral Di

9

State Registrar

2:20 P.M Barbara J. Ayres 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford 3747 Dublin Road Darlington 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Sept. 16, 1940 N. Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours Min. 1 □ M 2 🔀 F Yrs. 218-38-4811 68 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 21 No Director Harford Darlington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21034 United States 3747 Dublin Road Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑★o If Yes, Give Year or Dates: 1 ☐ Never Married 2XXMarried 1 □Yes 2ŽŽNo White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank James Hodge Hazel Moxley မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ayres / Husband 3747 Dublin Rd. Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 28. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air MEm. Gardens 5 ☐ Other (Specify) 2009 Bel Air, MAryland f Funeral Service/Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir Forest Hill, Maryland 21050 3 Newport Drive 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock are the complete shock or heart failure. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Onset and Death Immediate Cause (Final months encer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ZXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide 29a. Certifier TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0056607 April 27th 2009

DHMH 17 Rev 1/2001

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205,

32. Registrar's Sanature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN CLEL

0

S. ATWOOD Rd, BEZASR, MD 21014

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	ate of Maryland / [	·			0000	10070
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeam	2. Date of Death	g. No./     9	3. Time of Death
	Physici /Medic		Evelyn B. Ay	'ers			April :	2 ¹ 8 ^{8y} 200 ⁴ 9 ^{ar}	9:53a ^M
	Examin	ner	4a. Facility Name (If not institution, give street 907 Cord Street		4b. City, Town, or Mi	Location of Death	er	4c. County of Deat Baltin	more
Ī	Funeral		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. last bir	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birt Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	00			Dec.27	, 1920	MD
	within 72 hours after death with the Maryland jiene. Than "natural", or items 23a or 28a-f show the Medical Evanifuer must be multified at	ō	10a. State 10b. County  MD Baltimor	10c. City, Tow	n or Location Middle Riv	er			10d. Inside City Limits 1 □Yes 2 □ No
	r 28a-	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What Co	untry?
	23a c		907 Cord Street			21220		USA	
	items	Funeral	A	Vas Decedent Ever in U.S. Armed Forces? ☐Yes 2 X No	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
5-0036	ours aft ral", or Exami	þ	ا بعر	Yes, Give Year or Dates:	1⊡Yes 2 <b>x</b> No	Specify:		Specify: W	nite
ائے۔ ا	"natu	Completed	15. Decedent's Educatio (Specify only highest grade cor		. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	durina most of workin	_ 01	6b. Kind of Business/ Baltimore	,
717	within jiene.	dwo		College (1-4or 5+)	chool Bus	_		Public So	
and ?	it the	Be C	12th 17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	aiden Surname)	
5	should be and Mental s marked o umatic eve	오	Cooper Dorsey				ie Min		
Nar	ages 1 and 2 should be int of Health and Mental t: If item 27 is marked o		19a. Informant's Name/Relationship (Type. F Jerry Ayers /sor	·	o. Mailing Address <i>(Street a</i> 907 Cord S				
Baltimore,	es 1 al of Hei fitem rothe		20a. Method of Disposition	20b. Place or cemete	of Disposition (Name of ery, crematory or other plac	e) Da	1	Oc. Location - City or	
Ĕ	t. Pages tment of tant: If its ijury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	Holl:	y Hill Cem	etery 5/	1/09	Baltimo	re MD
g	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	HARD	22. Name and Address	ss of Facility y Funera	0 Mace 1 Home	Ave Ba	lto. MD C 21221
			23a. Palt 1. Enter the disease, or complication shock, or heart failure. List only one car	ns that can ed the death. Do use on each line.	1 .	. \			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	2hrouic	Obstruc	tire Po	Juina	ry	20 years
	Examiner			Due to (or as a consequence	of):	213	436		/
	±. q	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence	of).				
	xecute and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last c	Due to (or as a consequence	of):				
28/60,	ificate be executed g physician and as the burial-transit	edical E	d	Dao to (or as a someoquenes	<u></u>				
	certifica nding physe as the	Medi	IF FEMALE:						4 y
o n	eath atter for L	sician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy □ Live birth 2□ Fetal death □ Pregnant at time of death	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of del Month	ivery Day Year
	0 0 0	2		Unknown	5 🗆 Other (specify) _				
<u>, v</u>	w requires that the d s been signed by the should be detached	by P	Part II. Other significant conditions contribu	ting to death but not resulting in	n the underlying cause give	en in Part I.	NA	cco use contribute to	
cora	requir	eted	The officer	47	00470784	Ju	12 Yes		obably 4 🗌 Unknown
ř	0 % CJ	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
	ian: T	Be C	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2 (Check only one)		2 No
010	hysic this ce al direc	၉	examiner? 1  Yes 2 No Hospi	1 Inpatient 2 ER/Ou	<del></del>	4 L Nursing Horr	ne 5 Residen	ice 6 Other (Spe	cify)
VISION	Attending Physician: It death. ector: After this certific by the funeral director,	ation:	27. Manner of Teath 28 Natural 5 Pending Accident investigation		Time of 28c. Injury Work  M 1 □	yat ?? Yes 2 ∐No	8d. Ďescribe how	/ injury occurred	
	l or Atter after des Director	Certification:	2 Deviside 6 Deculd not be	Be. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
)	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifying Physicia	n: To the best of my knowledge On the basis of examination ar	e, death occurred at the tin nd/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
,7	To the within To the Comple	Me	29b. Signature and title of certifie	1	29c. License	e number	290	d. Date signed (Monti	h, Day, Year)
			· (Ma	nhow	D	18-32	6	4/291	2009
			30. Name and address of person who complete NAEEM GAUHA	ted cause of death (Item 23a)	(Type, Print) Coloral C	4R, 404	Easte	m, Bal	1, Day, Year) 2009 humane 400 21221
	Sta Registr		31. Date Ma (Youth, Day, Year)	32. Registrar's Signature					·west

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:15 PM 2009 /Medical Name (If not institution give street and number) or Location of Death **Examiner** 4c. County of Death Varyland altimor If Under 24 Hrs. Social Security Number 6. Sex Under 1 Year 8. Date of Birth (Month, Day, Apr 5, ] 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 214-20-3650 Director 83 Apr 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemples must be positived at Director MD 1√TYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2508 Banger Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2X No Specify \$ Specify: White 3 N Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bus driver school system permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Vest Emma Virginia Swann ျှ 19a. Informant's Name/Relationship (Type. Print) Sharon Nalbach/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Banger Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S, Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Citise (Final Approximate Interval Between Onset and Death Sepsis **Physician** disease or condition resulting in death) Sixdays /Medical Due to (or as a consequence of): six days Examiner mesenteric ischemia Sequentially list conditions, the property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Day ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9 ☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform death? certificate 1 □Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in completely within 2 To the I

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 22 S. Greene St

Registrar

29a. Certifier

09-03294 Bobby Avery

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Migrale, Last) Physician/ Reg. No Medical Examine 2. Date of Death 3. Time of Death Month Day April 24, 2009 1406 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1300 E. Lanvale Avenue #507 4c. County of Death Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director M Hours Min 13-22 2 F Foreian Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Gity Limits Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other thao "oatural", or items 23a or 28a-f she Director Yes 2 No 10e. Street and Number ner thao "oatural", or items 23a or 28a. Medical Examiner must he ootified at 10g. Citizen of What Country? Ja 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 14. Race - American Indian, Black 2 Married Armed Forces? Yes White, etc. 4 Divorced Widowed f Yes, Give Year ğ 1 Yes 2 No Specify 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) College (1-4 or 5+ isab 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 011 DO. 20b. Place of Disposition (Name of cernetery Cremation 3 crematory or other place) Removal from State Department Important: Donation 5 Other Specify -0 nounsoille the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medical Imm ate Cause (Final disease Between Onset and Examiner a Atherosclerotic Cardiovascular Disease or condition resulting in death) Death Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attendiog Physician: The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial. UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery Live birth past 12 months? 3 Ectopic pregnancy Fetal death Pregnant at time of death Year 1 Yes 2 No 9 Unknown Other (Specify) Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≦ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Vunknown After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 V No 25. Was case referred to medical Yes 2 No å 26. Place of Death (Check only one) Hospital: 1 Inpatient ۵ 1 🗸 Yes ER/Outpatient 3 Other _ Nursing Home 5 Residence 6 ✔ Other: Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural the f Pending 2 1___ Yes 2 ___ No Accident Investigation filled in by 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City determined Homicide or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 24, 2009 ame and address of person who completed ca e of deat (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

State Registra

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - For State Registrar		Marylar		artment o rtificate o			lental Hyg	giene Reg. No	2009	13975		
Physic /Medi		1. Decedent's Name (First, Middle, La  Daniel Philip Bi	,						2. Date of Dea Month	Day		3. Time of Death 2:50 AM M		
Exami		4a. Facility Name (If not institution, gir Stella Maris Hos	e street and numb	per)		4b. City, Town		n of Death	April	4c.	2009 County of Dea	ath		
Funeral Director		Social Security Number 6.		Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da	ar If Unde	er 24 Hrs.	8. Date of Birti (Month, Day 08/08/	y, Year)	9. Bir	thplace (State or Foreigrountry)		
r 28a-f show	Director	10a. State 10b. County  MD Baltimo  10e. Street and Number	ore		ty, Town or Lo		e			10a. Citi:	zen of What C	10d. Inside City Limits 1 □Yes 2 No		
vithin 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Madical Examinations by rutified at	by Funeral	1813 Wentworth Ro	12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No			Was Decedent of f Yes, specify C	21234 as Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:			1	14. Race - American Indian, Black, White, etc.  Specify:			
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faryland 2 2 should be filed v and Mental Hygi is marked other raumatic event, tr	To Be (	<ol> <li>Father's Name (First, Middle, Last</li> <li>Martin Bitzel</li> <li>Informant's Name/Relationship (</li> </ol>			19b. Mailir	a Address (Stre	Mil	dred	(First, Middle, I Hunter I Route Number			Zio Coda)		
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ding Phys	TO B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of li (Month, I		ER/Outpatient 28b. Time of Injury	28c. In	other: 4 🗀 No	ursing Hom	(Check only one le 5 ☐ Reside 8d. Describe ho	nce 6		cify) HOSPICE		
pital or ours afte eral Din filled in		3 Suicide 4 Homicide  6 Could not be determined	building,	etc. (Specify	/)	et, factory, office	9	2	City or Town	, State)		aral Route Number,		
To the Hos within 24 hr To the Fun completely		one X Nurse Pract  29b. Signature and title of certifier	itian en	s of examinat	tion and/or inv	29c. Lice	time, date and opinion, dealers number	ath occurre	d at the time, da	ate and p	and manner as place, and due signed (Month	to the cause(s)		
Stat Registra	e	30. Name and address of person who of JACKIE JONES, CRN 31. Date filed (Month, Day, Year)	P 2300		Y VALL		TIMON	NIUM,	MD 2109	93	ı			

DHMH 17 Rev 1/2001

2:40 а.ш.

APRIL 28, 2009

DANIEL BITZEL

State Registrar

31. Date filed (Month, Day, Year)

Day, Year) 32. Registrar's S

2. Aegistrar's Signature

Denne S. Sparks

mpleted cause of death (Item 23a) (Type, Print)

HWY PASADEMA

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Linda J. Bell April 2009 10:29 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10602 Partridge Lane Cockysville Baltimore 5. Social Security Number 220-38-6840 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth March 5 , 1942 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2 □ ME 67 Yrs Colorado Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Cockysville 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10602 Partridge Lane 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Westinghouse 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George T. Little Emily Piper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MArk J. Krieger /son 1548 Aldeney Avenue Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service 22. Name and Address of Facility 300 Mace Ave. Balto. MD Calle Connelly Funeral Home of Essex 23a. Part . Enter the disease, or contributions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OHN. DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, d a.h. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 23e. Did tobacco use contribute to the cause of death? en in Part I. Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 LXN 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show

with the Maryland

death

be filed within 72 hours after

Department of Health and Annual Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "na any injury or other traumatic event. The Induce.

3altimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

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Completed

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Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and physician y the attending phohe signed by the a

Exami Physician/Medical ð Completed page 2 should has been certificate this certific al director, Certification: To after death Director: A d in by the f

Division of Vital Records, P.O. Box 68760

1 ∐Yes 2VINo 9 □ Unknown	9 Unknown	5 🗆 Other (specify) _
art II. Other significant condition	ons contributing to death but not resulting in	the underlying cause giv

1 Yes 2	10	Ho	spital: 1 ☐ Inpatient 2 ☐	]
27. Manner of Death 1 Death	5 Pending		28a. Date of Injury (Month, Day, Year)	
2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be	- 1	00 - 01 - 11	

Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

determined 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) revaolet drive, Elicott 31. Date filed (Month, Day, Year) €2. Registrar's Signature

State Registrar

Medical

within 24 hours aft To the Funeral Di completely filled in

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 April 26, Craig Stephen Brooks 10:30 AMM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Dec 28, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 X M 2 □ F 218-44-3853 63 1945 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore ty⊡Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 E. Belvedere Avenue 21215 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐Yes 2X No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) grocer food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Rufus Brooks Myrtle Pauline Thigpen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Brooks/spouse 1701 Hartsdale Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Ronald SLicensee de State Anatomy Board 655 W. Baltimore Street ina Baltimore, MD 21201 23a. Part Lenter the disease, / conflications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Ca e (Final disease or condition resulting in death) Due to (or as a con equence of Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

MD

Director

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at

is marked other

or other per mit. Pages 1 am
De, artment of Heal
Important: If item 2
am injury or other

Pages 1 and 2 should be in nent of Health and Mental

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

law requires that the death certificate be execuattending physician

for use the funeral director, page 2 should be filled in by the

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After t

after death Director:

within 24 hours a

To the Funeral D

Physician: The certificate

Hospital or Attending

Vital

ot

Examiner Physician/Medical

Be Completed by Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Miner (Specify

2 🗆 No 1 ☐ Yes

	examiner?	modiodi
	1 ☐ Yes 2 ☐ No	
27	May prin of Death	

1 Natural

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

nificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 29b. Signature and title of certifier

29a. Certifier

30

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	(
Name and address of person who completed cause of death (Item 23a) (Typ	Prin

29c. License number

State Registrar

DHMH 17 Rev 1/200

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			1 - For State of Maryland / Departm Certific	ent of Health			iene _{eg. No.} 200	9 13979
	Dharaini		1. Decedent's Name (First, Middle, Last)		2.	Date of Deat Month	h	3. Time of Death
	Physici /Medio		Oscar K. Blake			04	Day Year 200	
7	Examin	er	0 : 1 //	City, Town, or Location	of Death		4c. County of Dea	
- and the second	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur	allSbury	er 24 Hrs.   8.	Date of Birth	Wicor.	thplace (State or Foreign
	Director		218-10-0433   1 M 2 F   91 Yrs.   Mont	ths Days Hours	Min. J	Date of Birth (Month, Day, an 19,	Year) C 1918 Mar	ountry) Vland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
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	r 28a	Director	10e. Street and Number 10f.	. Zip Code		1	0g. Citizen of What C	2.
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural", or items 23a or 28a-f show ent, It a Madical Examiner must be notified at	ralD	104 Stevens Road	21	863		USA	
	er dez items oerm	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De Armed Forces? 13. Was De If Yes, 15.	ecedent of Hispanic O specify Cuban, Mexica	rigin? (Specif	y Yes or No- an, etc.)	14. Race - Am Black, Whit	
39	Irs aft	by F	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Ye. 3 ☐ Widowed 4 ☐ Divorced Year or Dates;	s 2∭ No Specify	y:		Specify: 1	lack
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ary	2 shou and M is mai aumat	_		ress (Street and Numb	ber or Rural R	oute Number,	; City or Town, State,	Zip Code)
oʻ	and and lealth m 27 her tr			vens Road				
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		Date	2	20c. Location - Clty or	Town, State
Balt	permit. Departr Imports any inji			e and Address of Facil Anatomy E More, MD		55 W.	Baltimore	Street
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.			espiratory arre	est,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)  a. BND STAG-72 C	ARDIOM	YOPA	THY		Onset and Death
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Vital Records,	w requires that the beach bettillicate be executed been signed by the attending physician and should be detached for use as the burial-transit	d by		· g g				robably 4 Unknown
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Ĭ	ate ha	mo.				autopsy perform 1 🗆 Yes 🦠		completion of cause of
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OT	rthis c	2	1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   27. Manner of Death   28a. Date of Injury   28b. Time of		lursing Home			ocify) HCSPICIE
uo S	th: After fune	tion	27. Manner of Death   28a. Date of Injury   28b. Time of Injury   2   Accident investigation   M	28c. Injury at Work? 1 □ Yes 2 □		. Describe ho	w injury occurred	
VISION	ector ector by the	Certification: To	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact			Location (Str	reet and Number or R	ural Route Number,
בֿ בֿ	rs affe	Cert	4 Intrinside Building, etc. (Specify)			City or Town	,	
H	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s.	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigated and manner stated.	tion, in my opinion, dea	eath occurred a	at the time, da	ate and place, and du	e to the cause(s)
ţ	withir comp	Me	29b. Signature and title of certifier	29c. License number		29	d. Date signed (Mont	h, Day, Year)
			10 1	.Docs	2410		4/26/	9
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	les et	2.0.6	A 7 = 1	4-	
	Stat	ie.	31. Date filed (Month, Day, Year) S2. Registrar's Significant	1. 130 × 11	173 -	stus!	suig my	9-41202
Ţ	Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Strung & ARG CEASTAL HOSPICE  31. Date filed (Month, Day, Year)  MAY 0 1 2009  MAY 0 1 2009					

DHMH 17 Rev 1/2001

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Division of Vital Records, P.(	To the Hospital or Attending Physician: The law requires that the
Division	nital or Attending
1+	To the Hose

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hysician	1. Decedent's Name (First, Middle, Last)  John Milton Busky,	Tr				Day Year	3. Time of Death 7:30 AM M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	Jr.	4b. City, Town, or	Location of Death		4c. County of Death	
uneral rector	1⊠M 2□F	(In yrs. last birthda ₎ 74	Middle J y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 8/28/1934		place (State or Foreign Intry)
2	Usual Residence of Decedent	IOc. City. Town or I	ocation		0, 20,		10d. Inside City Limits
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanticar must be notified at once.  To Be Completed by Funeral Director		,,					1 □Yes 2 No
Director	Maryland Baltimore  10e. Street and Number	Middle R	10f. Zip Code		10g.	Citizen of What Cou	intry?
ra D	10 Shawqo Court		21220		U.	S. A.	
Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
by F	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1951	1 ☐ Yes 2 🛣 No	Specify:		Specify:	ite
ted	15. Decedent's Education	1959 16a. Dec	cedent's Usual Occup	ation	16b.	Kind of Business/I	
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Be		G					
욘	John Milton Busky,  19a. Informant's Name/Relationship (Type. Print)		iling Address (Street	<u>Dorothy</u> and Number or Rurai	Westp Route Number, Cit		ip Code)
	Johanna Busky (Wife)	10	Shawgo Cou	ırt Middl	e River.	Maryland	21220
	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp cemetery, cr	position (Name of rematory or other place		ate 20c.	Location - City or T	
	4 □ Donation 5 □ Other (Specify)		Veteran (		$\frac{5}{609}$ Gar	rison For	rest, MD
once.	21. Signature of Funeral Service Licensee		22. Name and Addre Bruzdzins	,	Home PA	_	
	23a, Part 1. Enter the disease, or an plical as hat caused the		Bruzdzins 1407 Old			ex, Mary	and 21221 Approximate
an al er		consequence of):	CATOIN		etton.		Interval Between Onset and Death
al Examiner	Sequentially list conditions.	consequence of):	Merci	rus	Lurce		
	resulting in death) Last Due to (ur as a	percus	pidemir	+			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	B	у		23d. Date of deli	very Day Year
b	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc		the cause of death?
olete					24a. Was an	24b. Were aut	opsy findings available
Completed					autopsy performed 1 Dyes 2 X	?   death?	ompletion of cause of 2   No
BeC	25. Was case referred to medical examiner?			26. Place of Death		/ · · · · · · · · · · · · · · · · · · ·	
	1X Yes 2 □ No Hospital: 1 □ Inpatient	2 ER/Outpat		4 🗆 Nursing non		6 ☐ Other (Spec	eify)
tion	27. Manner of Death  1 X Natural 5 Pending (Month, Day,)  2 Accident investigation	Year) 28b. Time Injury	/ Worl	y at k? Yes 2 □ No	8d. Describe how in	njury occurred	
Certification: To	o □ o i i i e G Could act bo	y - At home, farm, s (Specify)	street, factory, office		8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
Medical C	29a. Certifier  (Check only one)  1 **XCertifying Physician: To the best of and manner state and manner state.*	examination and/or					
M	29b. Signature and title of certifier	nell'	29c. Licens	939133	29d.	Date signed (Month	, Day, Year)
	30. Name and address of person who completed cause of dea	MD	107 B	EACOIL 1	Ro BA	TO MD	21220
State strar	31. Date filed (Month, Day, Year)  MAY 0 1 2009  Registrar	s Signature	re				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death EUGENE ERNEST BOYD Day 7) **Physician** 6-00 A M 12005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** unde eng Bnynse Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2□ F 232-24-8087 Director West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if item 22 or 28a-f show amy injury or other traumatic event, the Medical Experience and the supplied at once. GlenBurnie 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 387 Phirne Road USA Funeral 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced WW 2 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Chemical Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flakie Neal Ernest Boyd ပ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie D. Boyd (Wife) 387 Phirne Rd., Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 5/2/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Furreral Service Licensee Kevin E Ecker 237 E. PAtapsco Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death **Physician** IND WEEK disease or condition resulting in death) /Medical le to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Rec6rds, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No urs after death.

eral Director: After this certificate has been signed by the ifiled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an 1 □Yes 2 No 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ↑☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fixertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hou To the Fune completely fi and manner stated. 29b. Signatule and title of certifier 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 1 2009

DHMH 17 Rev 1/2001

Tungenty Ros

82. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JUDITH YVONNE BELL 2009 2:15 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner THURKILL CT. COCKEYSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🔀 F 226-50-8057 69 Yrs. Director 9/6/1939 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Exercites mass be notified at Director 1 X Yes 2 No GROTTOS ROCKINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 3rd STREET 24441 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Completed by Specify: 3 ☐ Widowed 4 1 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY INVESTMENT CO. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Oris Bodkin Mary Willadean Knott ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Healtr Important: If item 27 any Injury or other tr PAMALA RIGGER - DAUGHTER Thurkill CT., COCKEYSVILLE, MD 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PATAPSCO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 5/1/09 PATAPSCO, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Par 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or leart failure. List only one cause on each line. Immediate ause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate 2 No 1 □Yes 2 4 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 COther (Specify) NUGHTERS 1 Yes 2 ₩o this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALMOUD 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Deat 2<u>009</u> Physician Bushallow April  $A^{M}$ 27 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Oct. 22 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Year. 1**X** M 2□ F Months Days New York Director 057-24-2952 79 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov 1 X Yes 2 □ No Director Maryland | Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 University Blvd. #711 20895 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 Is marked other than "natural", or item Black, White, etc. 1 ☐ Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White al Hygiene.
d other than "natural event, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Bushallow Tekla Lukaschivich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 3333 University Blvd. #711 Kensington, MD 20895 Mary Bushallow 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 N Burial 2 □ Cremation 3 □ Removal from State St. Nicholas Cemetery 5/2/09 4 ☐ Donation 5 ☐ Other (Specify) Aurelius, NY 22, Name and Address of Facility Plis Funeral Home 220 State St., Auburn, 21. Signature of Furreral Service Licensee Unnec 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of) Severe Pleural Effusion Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Exami sician and burial-trans Pneumonia Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe

**Physician** /Medical Examiner

death

Baltimore, Maryland 21215-0036

Pages 1

Box 68760, Ö ٣. Records, page 2 should certificate Division of Vital Hospital or Attending Physician: director, this death.

Completed Be Certification: To funeral ( After t the Funeral Director, A

1 ∐ Yes 2 💢 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natura investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

D63579

29d. Date signed (Month, Day, Year)

April 27, 2009

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completely

within 2

Maria Tayag, MD 31. Date filed (Month, Day, Year) State

29b. Signature and title

30. Name and address of person who completed ca

1500 Forest Glen Rd., Silver Spring, MD 20910 32. Registrar's Signature

us of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 3984 Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 9:30 P M da April 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min. 1 □ M 2 X F 218-14-9606 89 Yrs. 01/15/1920 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 6503 PARK HEIGHTS AVENUE 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò Specify: WHITE 1 □Yes 2 No 2 Specify. 3 Widowed 4 Divorced 'natural", Completed h and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) RETAIL DEPARTMENT Elementary/Secondary (0-12) College (1-4or 5+) STORE SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MYER BAKER ပ္ ROSE WOLLMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. BETTYE KERSHNER / NIECE 412 DEER HOLLOW ROAD, MT. AIRY, MD 21771 20b. Place of Disposition (Name of BETHIE'S AND tory or other place) ADATH ISRAEL 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician almonary honic disease or condition resulting in death) bstruct /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1 □Yes 2 🗓 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 🗌 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and vitle of certifier 29d. Date signed (Month, Day, Year)

State

MAY 0 1 2009 Registrar

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

25 Ma 32. Registrar's Sic

cause of death (Item 23a) (Type, Print)

uite 200

pril 29,2009

Reisterstown, Md 21136

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3985 Reg. Not- U Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Blachowicz April 29,2009 12:00P^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FutureCare-North Point Eastpoint Baltimore 8. Date of Birth (Month, Day, Year) Sept19,1917 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 □ X F 217-05-7722 91 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 North Belnord Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ≱☐ No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Tailor Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Kujawa Anastasia Yurek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Stricker/Son-in-Law 3123 Woodhome Avenue Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem 5-2-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral home, PA Tolus 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (er an a consequence of): mer 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify)

**Physician** /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Department of Health a Important: If Item 27 is any Injury or other tra once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

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or Items 23a

72 hours after

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Pages -

Baltimore, Maryland 21215-0036

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Apr 201

Director

Funeral

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Hospital or Attending filled in by

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Division

9 ☐ Unknown	9□Unknown						
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
		24a. Was an autopsy performed?  1 Yes 2 Tho					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1	on (Month, Day Year) Injury Work?  M 1   Yes 2   No	3d. Describe how injury occurred					
3  Suicide 6  Could not 4  Homicide determine		off. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the vest of my knowledge, death occurred at the time, date and place, an aminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)					

29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item \$3a) (Type, Pfint)

16

within 24 hours a

To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

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		1 - State of Marylan		ificate of D		Reg.		
Physicia		1. Decedent's Name (First, Middle, Last)  Anna Marie Carter				Date of Death Month	Day Q Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number)	- 1	4b. City, Town, or L	ocation of Death	Q1	4c. County of Deat	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.   8, [	Date of Birth	N/A	hplace (State or Foreign
Director		217-30-5344 1 M 2XF	74 Yrs.	Months Days	Hours Min.	Date of Birth Month, Day, Ye G 2 193	4 Mai	yland
yland			ity, Town or Loca					10d. Inside City Limits
he Mar 28a-f sl	ector		Catonsv			1.0		1 ☐ Yes 2 <b>X</b> No
h with th	a Dir	109. Glenwood Avenue		10f. Zip Code <b>21228</b>	1	10g.	Citizen of What Co <b>USA</b>	untry?
urs a	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 M No If Yes, Give Year or Dates:		37	panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
215-0036 thin 72 hours aft an "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kir	nt's Usual Occupati nd of work done due NOT use retired)	ion ring most of working	16b	. Kind of Business/	Industry
d 2127 filed within Hygiene. wither than "	E O	Elementary/Secondary (0-12) College (1-4or 5+)		ntry C1	erk	Hi	gher Ed	ucation
and lbe file antal Hy ed oth	e e	17. Father's Name (First, Middle, Last)  Joseph Lubbehusen		1	8. Mother's Name (Fir	st, Middle, Maid Josit		
Mar nd 2 sho lith and 27 Is mar r traum	0	19a. Informant's Name/Relationship (Type. Print)  Thomas J. Carter, Sr. – husband			nd Number or Rural Ro	ute Number, Ci	ty or Town, State, 2	Zip Code) . <b>228</b>
Ore ges 1 frof H or oth		20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State	Place of Disposit cemetery, crema	ion (Name of tory or other place) ralCemet.	Date	20c	Location - City or	
Ealtim permit. Par Departmen Important: any Injury		21. Signature of Funeral Service License H. Williams	22 1	lacNabb Fi	uneral Hom	e, P.A.		
Physician		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition					VIIIC, IA	Approximate Interval Between Onset and Death
/Medical Examiner	ler	sell inse	quence of):	hear				5 day
8 / 6/ sate be sate be shysicia the bur	edical Examiner	Sequentially list conditions, if any, letting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequence of the consequence of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o	atte 1	breart	carelno	ma		9 ylar
death certif	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant at time of constitutions of the pregnant a	al death 3 □ E	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
S, F	2	Part II. Other significant conditions contributing to death but not resi	/		in Part I.			the cause of death?
1 2 a a (1)	Completed	- Progressed supro	<u> </u>	ar pac		1  Yes  24a. Was an autopsy performed	24b. Were au	topsy findings available completion of cause of
VITAL sician: T certificat rector, pa	200	25. Was case referred to medical examiner?			26. Place of Death (Ch	1 □Yes 2 ☑ neck only one)	No 1 □ Yes	2 No
ng Phys	2	1 Yes 2 No Hospital: 1 Inpatient 2 No No No No No No No No No No No No No	ER/Outpatient 28b. Time of Injury	28c. Injury a Work?	4 LI Nursing Home	5 Residence		cify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Director.	Cermicanon	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street	t, factory, office	28f. i	ocation (Street City or Town, St	and Number or Ruate)	ural Route Number,
le Hospif 24 hour le Funer stetely fill	Medical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my kno 2 **Medical Examiner: On the basis of examina and manner stated.	owledge, death o ation and/or inve	occurred at the time stigation, in my opir	e, date and place, and nion, death occurred a	due to the caus t the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To the County		29b. Signature and title of certifier  **Damea_ & Birches	Long	29c. License r	2114		Date signed (Monte	h, Day, Year)  \$ 2009
5		30. Name and address of person who completed cause of death (Item	A -	nt) DAMA	BALLA	MORE	ESS in	1129
State Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature		(			
DHMH 17 Rev 1/200		MAY 0 1 2009 Gener S.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 15 AM CLARKE UAIST APRIL 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SECOUR HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours 90 **Director** June 8,1918 Jamaica,WI 216-59-9623 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified #1 1 Yes 2 □ No N/A Directo Maryland Baltimore 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 2422 Calverton Heights Avenue by Funeral 21216 Jamaica 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 □ Divorced 'natural", Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12th grade Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ever Charles Limonius ပ Keturah Limonius 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 permit. Pages 1 and 2 g Department of Health a Important: If item 27 Is any Injury or other trau once. Joyce Sims/ Daughter 2422 Calverton Heights Ave Baltimore Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 5/9/09 Alberton, Trelawny, WI 21. Signature Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faylure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE KID NEY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transi Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> FN DO CARDITIS 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 PNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

P.O. Box 68760. Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: After din by the furnishment investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30272 meen AFRIL 26

Bow

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SECOURS HUSPITAL

BATTMONO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year APRIL 27 Day 8:15 PM MARY ANNE COPELAND 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country)

New York Age (In yrs. last birthday) 1 □ M 2 💢 F 56 6/26/1952 111-42-1128 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XIXI Yes 2 No Chester Wayne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19087 USA 872 Monteith Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 2 **2**No 1 Never Married 2 Married 1 ☐Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Tredyffrin-Eastown Elementary/Secondary (0-12) College (1-4or 5+) Teacher School District yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emilie O'Connell James Fahy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Maryland 21043 Brian J. Copeland/Son 7601 Coach Light Ln. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stretch Funeral Home: 5/1/2009 Havertown, PA 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 Ninth Street, NW Washington, DC 20011 23a. Pake Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final encephalit week Vival disease or condition resulting in death) Due to (or as a consequence of netastatic melanon Lavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 \( \square\) No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

**Physician** /Medical Examiner Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

PA

Director

Funeral

δ

Completed

Be

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be motified at

Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite

27 is marked traumatic e

Department of Health an Important: If item 27 is any injury or other trau

altimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

Hospital or within 24 hours a

death with the Maryland

Examiner ng physician and as the burial-trans Physician/Medical attending p signed by the a d be detached for <u>≨</u> certificate has been s irector, page 2 should Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be ۵ Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 2 X No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural 5 ☐ Pending investigation

28b. Time of Injury Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

2 Accident 3 Suicide

4 Homicide

29a. Certifier

01065743A

29d. Date signed (Month, Day, Year) 28m 2009

Suzanne M. Inchwiste M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> SUZANNE M. INCHAUSTE

6 ☐ Could not be

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12.perfh 13 per dvr 9891 5-4-09 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death CARTER STANL Day Month **Physician** 2009 5:25pm M 04 28 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 3751 Crestfield Court Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Sex 1 □ M 2 □ F Months Days Hours Min. Director 212-48-4527 08 29 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ral", or items 23a or 28a-f shore 1 Yes 2 No Directo Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. <u>3751 Crestfield Court</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 ★ No If Yes, Give ↑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes -X Specify. 3 ☐ Widowed 4 🛱 Divorced Specify: þ Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer McCormick and Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Blanche Faulkner Chester Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) 1629 North Dukeland Street, Baltimore, Blanche Carter-Mother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 5/8/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signatuk of Funeral Service License Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADENDCARC INDMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be execute physician and s the burial-trans Division of Vital Records, P.O. Box  $68760^{\circ}$ Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ς. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy performe certificate 1 □ Yes 2 X No lospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this illed in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes death. 2 🗌 No after death 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29¢. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REENE ST, BALTIMORE-MD-21241 10 RAJA CHANDRAKAL 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760, ___

	1 - For State Registrar			•	partment of F ertificate of		Re	ene g. No. 2 (	09	13990	
Physician	1. Decedent's I	Name (First, Middle, L	NAOMI		2. Date of Death Month April 28	Day 2009	Year	3. Time of Death 9:40 P M			
/Medical Examiner	As Estimated the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second				4b. City, Town, o	or Location of Death		4c. County	of Death		
Funeral Director	5. Social Secur 217–09	rity Number 6.		e (In yrs. last birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 29, 19	Year)	9. Birthp Cour Mary	place (State or Foreign htry) Land	
f show	Usual Residen 10a. State Maryland	10b. County		10c. City, Town or	Location Baltimore				1	0d. Inside City Limits 1≹ Yes 2 □ No	
h with the Mar 3a or 28a-f st at be notified	10e. Street and		live Street		10f. Zip Code	21230	10	g. Citizen of V	Vhat Cour	itry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rotified at once.  To Be Completed by Funeral Director	3 😾 Widow	tus Married 2 Married ed 4 Divorced	12. Was Decedent E Armed Forces? 1	Ever in U.S. 1	3. Was Decedent of HIfYes, specify Cub. 1 □Yes 2 X No		ecify Yes or No- Rican, etc.)		k, White,		
ed within 72 hou ygiene. ner than "natura" t, I're Medical E	Elementary/	15. Decedent's E Specify only highest g Secondary (0-12)	ducation ade completed)  College (1-4or 5	(G	cedent's Usual Occup five kind of work done e. DO NOT use retired Homemaker	pation during most of work d)	ing	Housewi		Justry	
Mental Hy arked other attic event,	17. Father's Na	ame (First, Middle, Las	John Jacob	s		_	e (First, Middle, Ma Lanche Watt		ne)		
and 2 sho ealth and I n 27 Is ma er trauma	19a. Informan	t's Name/Relationship d E. Woodward	(Type. Print) , III (Grand	son) 221	ailing Address (Street 1 N. Charles	ST., 3rd F	loor, Balti	more, Mo	1. 21	218	
Pages 1 ment of H ant: If iter ury or oth		f Disposition □ 2 🗷 Cremation 3 [ ion 5 🗆 Other <i>(Spec</i>	ify)	Bayview C	sposition (Name of rematory or other place rematory, Ind	c.   5/2/0	)9 B	oc. Location - altimore	e, Mar	yland	
permit Depart Import any Inj	21. Signature	of Funeral Service Lice	ensee Kevin E	Ecker	22. Name and Address 130 Fast 1	ess of Facility McC Fort Ave., I				e, P.A.	
Physicían /Medical Examiner	23a. Part 1. Er shock, or Immediate Ca disease or cor resulting in de	use (Final ndition	nplications that caused one cause on each tine.  a. A S C  Due to (or as a	the death. Do not e.  a consequence of):	enter the mode of dyi	ng, such as cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death	
icate be executed physician and the burial-transit	Sequentially list if any, leading cause. Enter leading that initiated erresulting in dea	vents	c	a consequence of):							
ate be hysicia he bur		•	<b>d</b>								
ath cer attendin or use			23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 🗌 Fetal death	3 □ Ectopic pregnanc 5 □ Other (s <i>pecify)</i> _	су				ery Day Year	
uires that the de a signed by the a de detached fid be detached fid by Physic		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba							o use contribute to the cause of death?		
The law require cate has been si page 2 should k							24a. Was an autopsy perform	ed?	Were auto prior to co death? 1 □ Yes	ppsy findings available impletion of cause of	
iclan: certific ector,	examiner?	referred to medical	Hospital:		siant all pos Oth		h (Check only one,	)			
Physical direction of To	1 ☐ Yes 27. Manner of		1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 L DOA	4 KU Nursing Ho	me 5 Resider		- ' '	ý)	
To the Hospital or Attending Physiclan; The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Notice) 28f. Location (Street and Number or Rural Route Noti							al Route Number,			
the Hospita ithin 24 hours the Funera ompletely fille	29a. Certifier (Check on one)	1☐ Certifying F 2☐ Medical Exa XCRN P	hysician: To the best of miner: On the basis of and manner sta	examination and/o	eath occurred at the ti r investigation, in my o	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and ma te and place,	anner as s and due to	itated. the cause(s)	
To t with To t		and title of certifier	mp		29c. Licens	05 808		d. Date signed	d (Month,	Day, Year)	
	30. Name and	eddress of person who	completed cause of de					e 200	Ba	Himpre, M	
State Registrar	31. Date filed (	(Month, Day, Year) 0 1 2009	32. Registra	ar's Signature						21209	

09-03422 Joseph Cayer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

узори очуск	F	1- For State Certificate of De		Reg	3. No. 2009 1399
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)     JOSEPH M. CAYER		2. Date of Death Month April 28, 20	Day Year 1520 hrs
		Tarris (a training of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the cont	ty, Town, or Location of D Itimore	eath	4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Under 1 Year If Under 2 onths Days Hours	Min. March 31	(MM/DD/YYYY) 9. Birthplace (State or Foreign
	F	Usual Residence of Decedent		1211(11)1	10d. Inside City Limits
nd show any kee		Maryland N/A Curtis	Bay		1 Yes 2 No
th the Maryland 23a or 28a-f show	Director	10e. Street and Number 4001 Farihavne Avenue Apt. 04	Zip Code 21225	10	ig. Citizen of What Country? U.S.A.
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	cedent of Hispanic Origin becify Cuban, Mexican, Pr	? ( Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. White
irs after c	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us	sual Occupation (Give kin		Specify:  16b. Kind of Business/Industry
0036 within 72 hours iene. rer than "natun Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) 2 Techni	working life. DO NOT us .Can.	e retired)	Air Pax Company
P 8 8 8 4		17. Father's Name (First, Middle, Last)		Name (First, Middle, M	Maiden Surname)
2121 hould be fil nd Mental F is marked tite event,	e Be	Joseph Alfred Cayer  19a, Informant's Name/Relationship (Type, Print )  19b. Mailing Add			Howser aber, City or Town, State, Zip Code)
e, MD 2 1 and 2 shou Health and N item 27 is n rr traumatic	ř			t, Glen Burn	ie, Maryland 21060
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition crematory or other playview Cremat	(Name of cemetery, lace) OTY	Date 04-30-09	20c. Location - City or Town, State  Baltimore, Maryland
Baltimore permit. Pages 1 Department of F Important: If injury or other	Ì	21. Signature of Fun relievice Licensee 3204 M	ly formilak tu untain Road,	neral Home P Pasadena, Ma	.A. ryland 21122
Physician	7	23a. Par . Enter the disease, or complications that caused the death. Do not enter the manual course. List only one cause on each line.			est, shock, or heart Approximate Interval Between Onset and
/Medical caminer		Armediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardi	ovascular d	isease	Death
	ē	Sequentially list conditions, If any, leading to immediate b. Due to (or as a consequence of):			
sit sit	Examiner	(Disease or injury that initiated events resulting in death) Last    C.    Due to (or as a consequence of):			
<b>0,</b> be executed sician and burial - transit	Medical E	Xunpended AMENDED 23a,27,perME, g8	91 5/12/09	TT	
8760, ificate be eving physiciar is the burial		IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal deceded to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	eath 3 Ectopic p	regnancy	23d. Date of delivery  Month Day Year
Box 687 e death certific the attending p	by Physician/	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)		
i, P.O. Boires that the designed by the			rlying cause given in Part		obacco use contribute to the cause of death?  s 2 No 3 Probably 4 ✔ Unknown
ds, l requires been sig	ᄝᅵ			24a. Was	
ecol he law tte has a	duc				rmed? death?
an: Ti	Se C	25. Was case referred to medical	26.Place of Death (C	Check only one)	
Vita	To B	examiner? 1 Ves 2 No Hospital:1 Inpatient 2 ER/Outpatient 3		Nursing Home 5	Residence 6 Other: Scene
on of rding P. th. :: After e funer	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	ı	now injury occurred
Division of Vital Records, P.O. ral or attending Physician: The law requires that the reading edeath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detace.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	actory, office building, etc.	28f. Location ( or Town, S	Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cal Ce	29a Certifier	at the time, date and plac	e, and due to the causurred at the time, date	se(s) and manner as stated.
To the vithing To the company	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Lasal Tweithall, MB	O.C.M.E.		April 29, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 F	enn Street, Baltimo	ore. MD 21201	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		510, WID 21201	
Regis		11 1 1 0 1 2000 /2			

Plea	ase Type or F						-	-	gible.	
For State Registrar	State of	i IVIai yiano		artment of F ertificate of				IENE eg. No. 🤈 🗍	nng	13992
Decedent's Name (First, Middle Eugene	Thomas	Campon	neschi	i. Sr.			2. Date of Death	9, Day 200	09 Year	3. Time of Death 6:55 a M
4a. Facility Name (If not institution Stella Maris		<del></del>	102	4b. City, Town, o	or Location o			4c. Coun	nty of Death	h
5. Social Security Number 213-26-9970	6. Sex 1 M 2 F	7. Age (In yrs. la. <b>7</b> 8	ast birthday) Yrs.		If Under	r 24 Hrs.	8. Date of Birth (Month, Day, Oct 20,		9. Birth	hplace (State or Foreign untry) ryland
Usual Residence of Decedent  10a. State 10b. County  MD W		y, Town or Lo							10d. Inside City Limits	
10e. Street and Number	Morcester		cean C	10f. Zip Code			10	og. Citizen o		MXYes 2 □ No untry?
9301 West Bisc	12. Was Deced	edent Ever in U.S.	i. 13. 1	Was Decedent of H	Hispanic Ori	rigin? (Sp	ecify Yes or No- Rican, etc.)		A. Race - Ameri Black, White,	
1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da		59	1 □Yes 2√√ No	Specify:			Spec	cify: W	White
15. Deceden (Specify only highes Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-	-4or 5+)	(Give . life. [	edent's Usual Occup e kind of work done o DO NOT use retired I i neer	during mos	st of worki	ng	Gover	Business/In	-
17. Father's Name (First, Middle, Guerino	,	poneschi		11100.	18. Mothe		e (First, Middle, Ma	laiden Surna		
19a. Informant's Name/Relationsi Dolores K. Cam	ship (Type. Print)		19b. Mailin	ing Address (Street )	t and Numbe	ber or Rura	al Route Number,	City or Towl	vn, State, Zip	
20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from S	20b. Pla	ace of Dispos emetery, crem	osition (Name of matory or other plac of Faith	ice)		Date 20	Oc. Location		Fown, State
21. Signature of Funeral Service		am G. Da	ıu 22 1	2. Name and Addres	ss of Facilit	y Ruc Tows	ck Towson		eral H	Home, Inc.
23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aCHOL	aused the death. ach line. ANGTOCAR or as a conseque	. Do not ente	ter the mode of dyin						Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate	b	or as a conseque								
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (c	Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	come of pregnanc pirth 2 Petal d nant at time of dea own	death 3 🗌	☐ Ectopic pregnancy	:y				Date of delive	very Day Year
Part II. Other significant conditio	ns contributing to dea	ath but not resulti	ing in the un	nderlying cause give	en in Part I.			acco use cor		the cause of death?
							24a. Was an autopsy performe	ed?	D. Were auto prior to co death? 1 □Yes	opsy findings available ompletion of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital:	npatient 2 = EF	P/Outpatier	nt 3 □ DOA Othe	ari		1 ☐ Yes 2 <b>]</b> n <i>(Check only one)</i> me 5 ☐ Besiden	)		ify) HOSPICE
27. Manner of Death  1 Natural 5 Pending 2 Accident investige	28a. Date of (Month)		28b. Time of Injury	f 28c. Injury Work		2	28d. Describe how			y) HUSPICE

Physician/Medical IF FEMALE: 23b. Was decede

≥

Completed

Be

Certification: To

Medical

Examine

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Director

Completed by Funeral

Be

ည

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Y

JONES, **CRNP** 31. Date filed (Month, Day, Year) State

one X Nurse 29b. Signature and title

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

TIMONIUM, MD 21093

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) rse Practitioner estated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of son who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

6 ☐ Could not be determined

Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 12:02 PM arolun, APR 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of maryland Medical (enter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2**X** F Months Days 212-40-4196 66 Director November 24, 1942 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Mudical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore Parkville 10e. Street and Number 10f, Zip Code 10g Citizen of What Country? 9504 Avondale Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Charles Hilseberg, Sr. Catherine Elizabeth Hoerner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9504 Avondale Rd., Parkville, Richard Chin / Husband MD21234 20b. Place of Disposition (Name of semetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hilltop Service Corp. 04-29-2009 Towson, Maryland 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. of Juneral Service Licensee 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis 3days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multiple Myeloma year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: **To the Funeral Director.** After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 XNo Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Was an autopsy performed? Yes 275 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 Accident 24 hours after death Pruneral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18179 Apr., 27, 2009 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atherine Smith 5. 22 St. Baltimore An Greene 21201 31. Date filed (Month, Day, Year) State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of M Amend Item 1 pe	r ar.,	gogle	Hilicate of	Death	R	Reg. No. ')	0 12001
Physician		an	1. Decedent's Name (First, Middle, Last) Rosmar		erger	Colmers		2. Date of Dea Month	th Day Ye	ar 3. Firme of Death
	/Medic	cal	Rosemarie Berge		Colme			April 2	28, 2009	2:50 a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number  Mercy Ridge	)		3.	r Location of Death		4c. County of D	
	Funeral		, , , , , , , , , , , , , , , , , , ,	ge (In yrs. la	ast birthday)	If Under 1 Year		8. Date of Birth		
	Director		064-20-4088 1 M 2 X F	83	Yrs.	Months Days	Hours Min.	8. Date of Birth 0ct 8,	1925 Au	Birthplace <i>(State or Foreign Country)</i> ISTP1a
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Baltimore		Timo	nium				1 □ Yes 2 🙀 No
	or 28;	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	
	ath wi	ral	2525 Pot Spring Rd			21093			U.S.	Α.
ď	be filed within 72 hours after death with the Maryland the Hygiene.  Hygiene.  d other than "natural", or items 23a or 28a-f show event, I'm Madical Evaning rulet be notified at	Funeral Director	11. Marital Status  12. Was Decedent Armed Forces  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑	?		Was Decedent of H fYes, specify Cuba I□Yes 2 <b>X</b> No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- Rican, etc.)	Black, W	
Ā » M . Marvland 21215-0036	ural",	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:						Specify:	White
r.	in 72 l	olete	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done OO NOT use retired	ation during most of working d)	g	16b. Kind of Busine	ss/Industry
21.0	d withii giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+	5+)		memaker	-/		Own hom	ne
2	tal Hygi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname)	
. N		ဥ	William V. Berge	r			Mathild		osch	
			John M. Colmers-son	ļ			and Number or Rural Terrace,			e, Zip Code) 21218
2:50	Pages 1 arent of Heren int: If Item		20a. Method of Disposition  1 ☐ Burial 2 【Cl Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla cei Hill	ace of Dispo metery, cren top S	sition (Name of natory or other place erv Corp	Da 4/29/		20c. Location - City Towson,	
<u>=</u>	permit. Pages 1 Department of 1 Important: If ite any Injury or ot once.		21. Signature of Funeral Servi Licensee William	G. Da	ıu 22	. Name and Addre	ss of Facility Ruck Rd., Tows	Towson	=	Home, Inc.
			23a. Part 1. Enter the disease, or complications that cause	d the death.						Approximate Interval Between Onset and Death
	Physician		shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition							
	/Medical		resulting in death)  Due to or as	a conseque	ence of):	Chall	MILLINE			weeks
====	Examiner		Sequentially list conditions, b.	enal		arcino	Ma			Months
9 5	utêd nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a conseque	ence of).					
SM	execu an and ial-tra	Examiner	that initiated events resulting in death) Last C Due to (or as	a conseque	ence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-		
28, 2 68760	rificate be executed g physician and as the burial-transit	edical	d							
		Med	IF FEMALE:	-						
APRIL O Box	requires that the death cert een signed by the attendin nould be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal o	death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
	w requires that the disben signed by the should be detached	ysic	1 □Yes 2 2 No 4 □ Pregnant a g □ Unknown	at time of de	alli 5L	Other (specify) _				
Ω C	s that	y P	Part II. Other significant conditions contributing to death b	out not result	ting in the ur	derlying cause giv	en in Part I.	23e. Did tol	pacco use contribute	e to the cause of death?
LMERS cords	equire sen si	ted						1 □ Ye	es 2⊠No 3□	Probably 4 Unknown
00		Completed						24a. Was an autops	y prior ned? death	
Vital	slan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 (Check only on		′es 2 ⊠No
SIE of V	Physiclan: this certific ral director,		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati		R/Outpatien		4 LI Nursing Hom		ence 6-ParOther (S	issisted Living
WAR	ttending Physical distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution of the funeral distribution	ion	27. Manner of Death  1 Natural 5 Pending (Month, Death Investigation)	ary ay, Year)	28b. Time of Injury	28c. Injur Work	yat ⟨? Yes 2 ∐No	3d. Describe ho	ow injury occurred	
ROSEMARIE Division of	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inj	ury - At hom	ne, farm, stre	et, factory, office		3f. Location (St	reet and Number or	Rural Route Number,
RC	ital or urs afte ral Dire	Certification: To	4 Entimode building, et	c. (Specify)				City or Towr	n, State)	
	To the Hospital or Attending Physiclan: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination	ledge, death on and/or in	occurred at the tire vestigation, in my o	ne, date and place, a	nd due to the c d at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	(1	Jacobs	29c. Licens	e number	2	9d. Date signed (Mo	onth, Day, Year)
	2	}	30. Name and address of person who completed cause of c	death (Item 2	23a) (Type, 1	Print)	, - , [ (		117/11	0
	J		ERNESTINE WRIGHT, M.D. 2	300 DI	JLANEY	VALLEY .	ROAD TIMO	NIUM, N	MD 21093	
	Stat Registra		31. Date filed (Month, Day, Year) 37 Registral RAY 0 1 2009	rar's Signatu	re fac	Kar				

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 399 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year APRI M 200 2:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Saint Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 ☐ M 2 🗹 F Director al timore Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5.1 Funeral ゟ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life ODO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Hair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evons Funera 4/2 C

22. Name and Address of Eacility

23. Name and Address of Eacility 9 KTUN 40 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) forest Hill, mo 21. Signature of Funeral Service Licenses neral Chapel-monkton monkton MD Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK HOURS /Medical Due to (or as a consequence of): Examiner PSEUDOMEMBRANOUS COLITIS 48 HOURS Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed and CLOSTRIDIUM DIFFICILE INFECTION burial-tran 48 HOURS Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 page 2 should Completed 1 X Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an has autopsy The performed? certificate Vital 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 🗆 No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the nd title of ce 29b. Signatura 29c. License number 29d. Date signed (Month, Day, Year) ATHOUGIS" D34543 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State

Registra

31. Date filed (Month, Day, Year)

AXE.

Y

D. 7571 ( 32. Registrar's Signature

park

OSLER DRIVE, TOWSON, MARYLAND 21204

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IV	iaryiand / Depa <i>Cei</i>	rtificate of Dea		, 0	erie g. No. 🤈 🗎 🗎 🗎	12006			
	Physicia	ın.	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Dav Year	3. Time of Death			
	/Medic		Jacqueline R. DiDor	28, 2009	3:15 P. ^M							
	Examin	er	4a. Facility Name (If not institution, give street and number Gilchrist Care Center	)	4b. City, Town, or Loca  Towson		4c. County of Death  Baltimore	1				
a de la constante	Funeral			ge (In yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth	0 Right	nplace (State or Foreign			
	Director		220–36–0932 ^{1□ M 2□} xF	69 Yrs.	Months Days Ho	ours Min.	Dec. 16,	1939 Mary	land			
	pur ,	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits			
Aaryla f sho	o	Maryland Harford		tsville				1 □Yes 2 X No				
	r 28a-	Director	10e. Street and Number	barree	10f. Zip Code		10	g. Citizen of What Cou	untry?			
	h with		1529 Baldwin Mill Road		21084		Uı	nited State	es			
	r dear	Funeral	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spe exican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modal Eventh or must be neithed.	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 □Yes 2 ☑ No <i>Sp</i>	ecify:		Specif <b>W</b> hit	<b>a</b>			
21215-0036	2 hour	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		10	6b. Kind of Business/I				
2	thin 7 le.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	life I	kind of work done during DO NOT use retired)	g most of workir	ng					
7	led wi tygier her th		12	Hc	memaker	Mashada Mara	/Firet Adiable Ad	Own Home				
ano	intal Fed ot	Be	17. Father's Name (First, Middle, Last)  Emmanuel Farriera				(First, Middle, Ma Ze Butkus					
Maryland	should nd Me mark imatk	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and N				ip Code)			
S	alth a 27 is or trat		Frank A. DiDonato, Jr./Hus	I	Baldwin Mil							
ore,	es 1 a of He filtem		20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place)	May ^D	ate 20	0c. Location - City or 1	own, State			
Ĕ	ment mant: I		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Highview	Mem. GArden	1S 200	)9 Fa	allston, Ma	aryland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Michael Exhibit in usel be notified at once.		21. Signature of Funeral Service Licensee	Ev	2. Name and Address of Vans Funeral Newport Dri	Chapel ve Fore	l & Crema	ation Serv	ice-BelAir 21050			
			23a. Part1. Enter the disease, or complicating that cause shock, or heart failure. List only one dause on each	ed the death. Do not ent					Approximate Interval Between			
- Same	Physician	4	Innerediate Cause (Final disease or condition a. METASTATIC UTERINE CANCER MONTHS									
	/Medical Examiner		resulting in death)	s a consequence of):								
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as	s a consequence of):				-				
1.	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or highly that initiated events C.									
0	e exe sian al urial-t	Ä	resulting in death) Last Due to (or as	s a consequence of):								
687600	eath certificate be executed attending physician and for use as the burial-transit	edical	d									
×	certifi nding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	e of pregnancy				23d. Date of deli	verv			
. Box	death e atte d for i	Physician/N	in the past 12 months?		☐ Ectopic pregnancy ☐ Other ( <i>specify</i> )			Month	Day Year			
P.O.	at the I by th	hys	9 Unknown									
ŝ	res that the de signed by the a be detached to	ρ	Part II. Other significant conditions contributing to death	out not resulting in the ur	nderlying cause given in	Part I.	23e. Did toba	acco use contribute to	the cause of death?			
Š	w requir been s should	eted	Philmonary 1-mbousm									
Vital Records,	e has	Completed					24a. Was an autopsy performe	prior to d	topsy findings available ompletion of cause of			
ta	an: The tifficate or, pa		25. Was case referred to medical		26	Place of Death		Mando 1 ☐ Yes	2 🗆 No			
<u> </u>	ysicia iis cer direct	To Be	examiner?	ient 2 ☐ ER/Outpatier	Other		-		ity) HOSPICE			
0	nding Physician: The la th. :: After this certificate ha: e funeral director, page 2	L:uo	The training from the Committee of the Control (Obesity) HUSA									
Sio	• Attendil er death. rector: A by the fu	catio	2 Accident investigation M 1 Yes 2 No									
Division of	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Number or Town, State)									
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. To the Lunaral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 CertifyIng Physician: To the bes									
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis and manner s	of examination and/or in tated.	vestigation, in my opinior	n, death occurr	ed at the time, dat	te and place, and due	to the cause(s)			
29b. Signature and title of certifier  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DAN HULL DOBLEMAN, MD 6505 NCHARLES ST, 8N FT 109 BALTIMONE)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature								d. Date signed (Month				
								PRIL 28, 20	009			
	B		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	9 KM	TIMME. IL	11 21204				
	Sta	te	31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	- CII CIVIL DO	1074	1. 101011	-0 21201				
	Registr	ar	MAY 0 1 2000									

DHMH 17 Rev 1/2001

09-03278 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Delker State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 2054 hrs William Lewis Delker April 23, 2009 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** St. Agnes Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Nov. 14, 1952 56 Months Days Hours Min. 220-60-8574 X M Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 X No Lansdowne Baltimore MD or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Directo 10f. Zip Code 21227 10g. Citizen of What Country 10e. Street and Number United States 100 4th Street Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: White Yes 2 X No specify: f Yes, Give Year Widowed 4 Divorced or other traumatic event, the Medical Examiner ₹ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Communications 12 Radio Installer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Audrey May McAfee William Lewis Delker, Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Orchard Avenue, Baltimore, MD 21225 Randy Delker - Brother 20c. Location - City or Town, State Date 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Lock a Tile Park X Burial Cremation 3 4-28-2009 Woodlawn, Maryland Dohation 5 Other Specif 22. Name and Address of Facility 22. Name and Address of Facility Ambrose 2719 Hammonds Fry Rd., 27227 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit nysician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, rate or Attending Physician: The law requires that the death certificate by 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown Unknown 된 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Completed ficate has been si, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? this certificate has performed? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Ве examiner? Hospital: Other; Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Apr 23, 2009 Pedestrian struck by auto 2000 hrs Natural Yes 2 V No neral Director: , filled in by the f Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) Hollins Ferry Rd. & 5th Avenue, Lansdowne, MD determined (Specify) Local Street To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

distrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Month Year **Physician** 1:45 A M April 29,2009 Louis George Ermer, Sr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Nursing Home If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∏M 2□F 87 Director 216-16-2172 Nov. 26, 1921 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or items 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2XXX0 Nottingham Baltimore MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 8100 Rossville Blvd Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? t⊟Xes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "naturel" Ith and Mental Hygiene. 27 is marked other then "natur treumatic event, it a Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Water Quality Control Tech 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clara Weikert Charles Jacob Ermer 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 8100 Rossville Blvd.Nottingham, Maryland 21236 19a. Informant's Name/Relationship (Type, Print) Julia Ermer-spouse item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If its eny injury or ot once. 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland Moreland Memorial Pk. May 2,2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,MD 21234 andrae AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 705a5/2 Immediate Cause (Final disease or condition resulting in death) NEUMUNIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Data to for as a consuduance off-Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an this certificete 1 Yes & No : After this certifice funeral director, t or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1-Natural is efter dec. 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 120058570 Good Samaritum Hospital Bultimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance L. Baken MD 626 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Regist<u>rar</u> GANGA REDNAM 3001 SOUTH HANCVER STREET, BALTIMORE

31. Date filed (Month, Day, Year)

NAY 0 1 2009

A Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 5:45A 26 April Albert Harry Evler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Northampton Manor Health Center 8. Date of Birth (Month, Day, Ye Nov. 19, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours Min 1 X M 2 □ F 1916 Maryland 92 220-10-5574 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experience must be rediffed at 1 □Yes 2 XNo Director Woodsboro Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21798 U.S.A. 9922 Pine Tree Road Funeral e filed within 72 hours after death val Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 🔀 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) commercial College (1-4or 5+) Elementary/Secondary (0-12) carpenter construction 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Mary Irene Keeney James Albert Eyler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary A. Eyler/ wife Woodsboro, MD 21798 9922 Pine Tree Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2009 | nr. Libertytown, MD Chapel Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility HartzlerFuneral Home 21. Signature of Funeral Service Licens Woodsboro, MD 21798 404 S. Main St. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy The law requires that the death in the past 12 months? 5 ☐ Other (specify) been signed by the should be detached □Yes 2□No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 → NO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 l or Attending Physician: after death. 25. Was case referred to medical examiner? To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Arursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Hospital 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0031058 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Gene Ashe

31. Date filed (Month, Day, Year)

Woodsboro, MD 21798

10200 Coppermine Rd.

32 Registrar's Signature